



Facility Name & ID Number MCKINLEY COURT

# 0042499 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	150	Skilled (SNF)	150	54,750	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	150	TOTALS	150	54,750	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,419	3,086	12,080	20,585	8
9	SNF/PED					9
10	ICF	18,540	10,558	907	30,005	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,959	13,644	12,987	50,590	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.40%

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 02/01/1997

J. Was the facility purchased or leased after January 1, 1978?

YES  Date 02/01/1997 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 11,953

Medicare Intermediary WPS(WISCONSIN PHYSICIANS SERVICES)

**IV. ACCOUNTING BASIS**

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

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
	<b>A. General Services</b>										
1	Dietary	229,651	52,753	12,519	294,923		294,923	2,381	297,304		1
2	Food Purchase		275,859		275,859		275,859	(2,902)	272,957		2
3	Housekeeping	197,946	46,658		244,604		244,604	1,900	246,504		3
4	Laundry	153,007	53,025		206,032		206,032	(60)	205,972		4
5	Heat and Other Utilities			156,523	156,523		156,523		156,523		5
6	Maintenance	87,940	45,045	82,062	215,047		215,047	2,001	217,048		6
7	Other (specify):*			29,538	29,538		29,538		29,538		7
8	<b>TOTAL General Services</b>	668,544	473,340	280,642	1,422,526		1,422,526	3,320	1,425,846		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			30,000	30,000		30,000		30,000		9
10	Nursing and Medical Records	2,253,148	180,239	88,932	2,522,319		2,522,319	(39,896)	2,482,423		10
10a	Therapy	51,061		150	51,211		51,211		51,211		10a
11	Activities	113,443	14,841	16,663	144,947		144,947	2,201	147,148		11
12	Social Services	25,242		2,912	28,154		28,154		28,154		12
13	CNA Training										13
14	Program Transportation			2,177	2,177		2,177		2,177		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,442,894	195,080	140,834	2,778,808		2,778,808	(37,695)	2,741,113		16
	<b>C. General Administration</b>										
17	Administrative	127,625		385,404	513,029		513,029	(382,556)	130,473		17
18	Directors Fees										18
19	Professional Services			423,685	423,685		423,685	(255,773)	167,912		19
20	Dues, Fees, Subscriptions & Promotions			153,976	153,976		153,976	(116,772)	37,204		20
21	Clerical & General Office Expenses	203,744	38,987	62,860	305,591		305,591	199,769	505,360		21
22	Employee Benefits & Payroll Taxes			625,325	625,325		625,325		625,325		22
23	Inservice Training & Education										23
24	Travel and Seminar			7,319	7,319		7,319	9,536	16,855		24
25	Other Admin. Staff Transportation			13,798	13,798		13,798		13,798		25
26	Insurance-Prop.Liab.Malpractice			180,620	180,620		180,620	5,334	185,954		26
27	Other (specify):*			195,969	195,969		195,969	(195,969)			27
28	<b>TOTAL General Administration</b>	331,369	38,987	2,048,956	2,419,312		2,419,312	(736,431)	1,682,881		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,442,807	707,407	2,470,432	6,620,646		6,620,646	(770,806)	5,849,840		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
<b>1</b>	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	10,387
	REPAIRS & MAINTENANCE	2,132
		0
		12,519
<b>3</b>	<b>HOUSEKEEPING</b>	
		0
		0
		0
<b>4</b>	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
<b>5</b>	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	36,111
	ELECTRICITY	108,150
	WATER	12,262
	CABLE TV - LOBBY	0
		0
		156,523
<b>6</b>	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	16,479
	PAINTING & DECORATING	703
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	39,828
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,040
	FIRE SERVICE	19,012
		0
		0
		0
		0
		82,062
<b>7</b>	<b>OTHER</b>	
	SCAVENGER	29,538
	SECURITY SERVICE	0
		0
		0
		29,538
<b>9</b>	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	30,000
		30,000

LINE	SCHED REF	TOTAL
<b>10</b>	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	0
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,215
	PHARMACY CONSULTANT XVIII B 39-2	1,200
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	86,517
		0
		0
		88,932
<b>10a</b>	<b>THERAPY</b>	
	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 CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	150
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		150
<b>11</b>	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	13,377
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	3,286
		0
		16,663
<b>12</b>	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	2,912
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,912
<b>13</b>	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	2,177
		0
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	385,404
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	24,647
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	399,038
		0
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	65,676
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	38,959
	EMPLOYEE WANT ADS XIX F	4,177
	CONTRIBUTIONS VI 20 XIX F	450
	DUES & SUBSCRIPTIONS XIX F	24,127
	LICENSES & PERMITS XIX F	3,035
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	7,602
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	4,950
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	1,200
	PATIENT BACKGROUND CHECKS XIX F	3,800
		153,976
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	5,880
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	2,395
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	1,055
	TELEPHONE	50,012
	MESSENGER SERVICE	3,518
		0
		62,860

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	253,991
	UNEMPLOYMENT COMPENSATION XIX D	90,534
	WORKERS COMPENSATION INSURANC XIX D	77,874
	HOSPITALIZATION INSURANCE XIX D	174,753
	EMPLOYEE BENEFITS - OTHER XIX D	9,341
	EMPLOYEE PHYSICAL EXAMS XIX D	2,642
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	16,190
	CHICAGO HEAD TAX XIX D	0
		0
		625,325
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	7,196
	TRAVEL XIX G	123
		7,319
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	13,798
		13,798
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	180,620
		180,620
27	<b>OTHER</b>	
	BAD DEBTS VI 24	195,969
		195,969

GRAND TOTAL COLUMN 3 OTHER **2,470,432**

**MCKINLEY COURT  
SCHEDULES  
12/31/2009**

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

TOTAL FOOD PURCHASE	275,859
LESS SALES TAX	<u>(2,902)</u>
NET FOOD	272,957
TOTAL PATIENT CENSUS	50,590
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	151,770
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	151,770
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	151,770
NET FOOD	272,957
DIVIDE TOTAL MEALS/YEAR	<u>151,770</u>
COST PER MEAL	1.80
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>
	=====

Facility Name &amp; ID Number

MCKINLEY COURT

#0042499

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	
	<b>D. Ownership</b>											
30	Depreciation			95,944	95,944	95,944	192,864	288,808				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			97,470	97,470	97,470	394,731	492,201				32
33	Real Estate Taxes			91,817	91,817	91,817		91,817				33
34	Rent-Facility & Grounds			576,000	576,000	576,000	(534,982)	41,018				34
35	Rent-Equipment & Vehicles			56,645	56,645	56,645	9,248	65,893				35
36	Other (specify):* STORAGE/MTG INS			7,580	7,580	7,580	29,840	37,420				36
37	<b>TOTAL Ownership</b>			925,456	925,456	925,456	91,701	1,017,157				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		423,012	645,385	1,068,397	1,068,397		1,068,397				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	<b>TOTAL Special Cost Centers</b>		423,012	727,510	1,150,522	1,150,522		1,150,522				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,442,807	1,130,419	4,123,398	8,696,624	8,696,624	(679,105)	8,017,519				45

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

Facility Name & ID Number MCKINLEY COURT

# 0042499

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(26,889)	30		9
10	Interest and Other Investment Income	(7,274)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,902)	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	(2,395)	21		18
19	Entertainment	(65,676)	20		19
20	Contributions	(5,400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,858)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(195,969)	27		24
25	Fund Raising, Advertising and Promotional	(38,959)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(7,602)	20		28
29	Other-Attach Schedule	33,940			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (320,984)</b>		<b>\$</b>	<b>30</b>

**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	
		<b>Amount</b>	<b>Reference</b>	
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)	(358,121)	PG 6-6D	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ (358,121)</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	<b>\$ (679,105)</b>		<b>37</b>

\*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
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>
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	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>	<b>47</b>

<b>BHF USE ONLY</b>					
48		49		50	51
					52

MCKINLEY COURTID# 0042499Report Period Beginning: 01/01/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 343	6	1
2	VACATION ACCRUAL	2,381	1	2
3	VACATION ACCRUAL	1,900	3	3
4	VACATION ACCRUAL	(60)	4	4
5	VACATION ACCRUAL	1,658	6	5
6	VACATION ACCRUAL	18,275	10	6
7	VACATION ACCRUAL	2,201	11	7
8	VACATION ACCRUAL	2,848	17	8
9	VACATION ACCRUAL	11,299	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING		19	11
12	MARKETING CONSULTANT	(4,905)	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	<b>Total</b>		33,940	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT# 0042499

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

## 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	2,381	0	0	0	0	0	0	0	0	0	0	2,381	1
2	Food Purchase	(2,902)	0	0	0	0	0	0	0	0	0	0	(2,902)	2
3	Housekeeping	1,900	0	0	0	0	0	0	0	0	0	0	1,900	3
4	Laundry	(60)	0	0	0	0	0	0	0	0	0	0	(60)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	2,001	0	0	0	0	0	0	0	0	0	0	2,001	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>3,320</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,320</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	18,275	0	0	(58,171)	0	0	0	0	0	0	0	(39,896)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	2,201	0	0	0	0	0	0	0	0	0	0	2,201	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	<b>TOTAL Health Care and Programs</b>	<b>20,476</b>	<b>0</b>	<b>0</b>	<b>(58,171)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(37,695)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	2,848	0	(192,702)	0	0	(192,702)	0	0	0	0	0	(382,556)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(8,763)	12,056	7,673	889	(267,628)	0	0	0	0	0	0	(255,773)	19
20	Fees, Subscriptions & Promotions	(117,637)	0	256	56	553	0	0	0	0	0	0	(116,772)	20
21	Clerical & General Office Expenses	8,904	0	10,510	1,979	178,376	0	0	0	0	0	0	199,769	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	194	3,933	5,409	0	0	0	0	0	0	9,536	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	1,176	1,732	2,426	0	0	0	0	0	0	5,334	26
27	Other (specify):*	(195,969)	0	0	0	0	0	0	0	0	0	0	(195,969)	27
28	<b>TOTAL General Administration</b>	<b>(310,617)</b>	<b>12,056</b>	<b>(172,893)</b>	<b>8,589</b>	<b>(80,864)</b>	<b>(192,702)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(736,431)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(286,821)</b>	<b>12,056</b>	<b>(172,893)</b>	<b>(49,582)</b>	<b>(80,864)</b>	<b>(192,702)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(770,806)</b>	<b>29</b>

## STATE OF ILLINOIS

Facility Name & ID Number MCKINLEY COURT# 0042499

Report Period Beginning:

01/01/2009 Ending:

Summary B

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(26,889)	215,408	104	340	3,901	0	0	0	0	0	0	192,864	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,274)	402,005	0	0	0	0	0	0	0	0	0	394,731	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	1,499	39,519	0	0	0	0	0	0	(534,982)	34
35	Rent-Equipment & Vehicles	0	0	3,488	4,512	1,248	0	0	0	0	0	0	9,248	35
36	Other (specify):*	0	29,840	0	0	0	0	0	0	0	0	0	29,840	36
37	<b>TOTAL Ownership</b>	<b>(34,163)</b>	<b>71,253</b>	<b>3,592</b>	<b>6,351</b>	<b>44,668</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>91,701</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(320,984)	83,309	(169,301)	(43,231)	(36,196)	(192,702)	0	0	0	0	0	(679,105)	45

Facility Name & ID Number MCKINLEY COURT

# 0042499

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

**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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 RENT	\$ 576,000	MCKINLEY AVE, LLC		\$	\$(576,000)	1
2	V	36 MORTGAGE INSURANCE		" "		29,840	29,840	2
3	V	30 DEPRECIATION - BLDG/IMP		" "		215,408	215,408	3
4	V	30 DEPRECIATION - EQPT		" "				4
5	V	32 AMORTIZATION - MTG COST		" "		4,347	4,347	5
6	V	32 INTEREST - MORTGAGE		" "		397,658	397,658	6
7	V	19 OTHER PROFESSIONAL		" "		250	250	7
8	V	19 ACCOUNTING FEES		" "		11,656	11,656	8
9	V	19 DATA PROCESSING		" "		150	150	9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 576,000			\$ 659,309	\$ * 83,309	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		\$ 64,081	\$ 7,673	15
16	V	20 DUES & SUBSCRIPTIONS		"		256	256	16
17	V	21 CLERICAL		"		10,510	10,510	17
18	V	24 TRAVEL		"		194	194	18
19	V	26 INSURANCE		"		1,176	1,176	19
20	V	35 RENT - EQPT & VEH		"		3,488	3,488	20
21	V	17 ADMINISTRATION	192,702	"			(192,702)	21
22	V	30 DEPRECIATION		"		104	104	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		\$ 249,110			\$ 79,809	\$ * (169,301)	39

\* 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		\$ 28,346	\$ (58,171)
16	V	19 PROFESSIONAL FEES		"		889	889
17	V	20 DUES & SUBSCRIPTIONS		"		56	56
18	V	21 CLERICAL		"		1,979	1,979
19	V	24 TRAVEL		"		3,933	3,933
20	V	26 INSURANCE		"		1,732	1,732
21	V	30 DEPRECIATION		"		340	340
22	V	34 RENT		"		1,499	1,499
23	V	35 RENT - EQPT & VEH		"		4,512	4,512
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			\$ 43,286	\$ * (43,231)

\* 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		\$ 2,276	\$ (267,628)
16	V	20 DUES & SUBSCRIPTIONS		" "		553	553
17	V	21 CLERICAL		" "		178,376	178,376
18	V	24 TRAVEL		" "		5,409	5,409
19	V	26 INSURANCE		" "		2,426	2,426
20	V	30 DEPRECIATION		" "		3,901	3,901
21	V	34 RENT		" "		39,519	39,519
22	V	35 RENT - EQPT & VEH		" "		1,248	1,248
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		\$ 269,904			\$ 233,708	\$ * (36,196)

\* 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	\$ 192,702	CHESTERFIELD, LLC		\$	\$ (192,702)
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		\$ 192,702			\$ 0	\$ * (192,702)

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

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: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	193,799	4	\$ 245,485	\$ 50,590	\$ 64,081	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	193,799	4	979	50,590	256	2
3	21	CLERICAL	PATIENT DAYS	193,799	4	3,807	50,590	994	3
4	24	TRAVEL	PATIENT DAYS	193,799	4	743	50,590	194	4
5	26	INSURANCE	PATIENT DAYS	193,799	4	4,504	50,590	1,176	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	193,799	4	13,362	50,590	3,488	6
7	21	CLERICAL	DIRECT HOURS	1	1	9,516	9,516	9,516	7
8	30	DEPRECIATION	PATIENT DAYS	193,799	4	400	50,590	104	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					\$ 278,796	\$ 9,516	\$ 79,809	25

Facility Name & ID Number MCKINLEY COURT

# 0042499 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	\$ 28,346	\$ 28,346	1	\$ 28,346	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	549,185	11	9,656	50,590	889	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	603	50,590	56	3
4	21	CLERICAL	PATIENT DAYS	549,185	11	21,492	50,590	1,979	4
5	24	TRAVEL	PATIENT DAYS	549,185	11	42,708	50,590	3,933	5
6	26	INSURANCE	PATIENT DAYS	549,185	11	18,809	50,590	1,732	6
7	30	DEPRECIATION	PATIENT DAYS	549,185	11	3,694	50,590	340	7
8	34	RENT	PATIENT DAYS	549,185	11	16,279	50,590	1,499	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	549,185	11	48,990	50,590	4,512	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				\$ 190,577	\$ 28,346		\$ 43,286	25

Facility Name & ID Number MCKINLEY COURT

# 0042499 Report Period Beginning: 01/01/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	549,185	11	\$ 24,702	\$ 50,590	\$ 2,276	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	549,185	11	6,002	50,590	553	2
3	21	CLERICAL	PATIENT DAYS	549,185	11	215,149	50,590	19,820	3
4	24	TRAVEL	PATIENT DAYS	549,185	11	58,719	50,590	5,409	4
5	26	INSURANCE	PATIENT DAYS	549,185	11	26,340	50,590	2,426	5
6	30	DEPRECIATION	PATIENT DAYS	549,185	11	42,349	50,590	3,901	6
7	34	RENT	PATIENT DAYS	549,185	11	428,990	50,590	39,519	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	549,185	11	13,546	50,590	1,248	8
9	21	CLERICAL	DIRECT HOURS	1	1	158,556	1	158,556	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					\$ 974,353	\$	\$ 233,708	25

Facility Name & ID Number

MCKINLEY COURT

# 0042499

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

**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		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			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	RELATED PARTY - MCKINLEY AVE, LLC						\$	\$		\$	1						
2	BERKADIA		X	MORTGAGE	\$39,218.00	07/2002	6,375,000	5,934,978	07/2037	6.6600	397,658						
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YEARS		152,161	118,866			4,347						
4											4						
5											5						
<b>Working Capital</b>																	
6	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/99	475,000	3,221,259	DEMAND	VARIES	96,633						
7	LETTER OF CREDIT FEE		X								837						
8											8						
9	TOTAL Facility Related				\$39,218.00		\$ 7,002,161	\$ 9,275,103			\$ 499,475						
<b>B. Non-Facility Related*</b>																	
10	IRS, IDR, ETC		X	LATE FEES							10						
11											11						
12											12						
13											13						
14	TOTAL Non-Facility Related						\$	\$			\$						
15	TOTALS (line 9+line14)						\$ 7,002,161	\$ 9,275,103			\$ 499,475						

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

1. Real Estate Tax accrual used on 2008 report.		\$	<b>87,000</b>	<b>1</b>
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.)		\$	<b>87,217</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>217</b>	<b>3</b>
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>91,600</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$		<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>91,817</b>	<b>7</b>
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	<b>77,987</b>	<b>8</b>	
	2005	<b>81,438</b>	<b>9</b>	
	2006	<b>82,847</b>	<b>10</b>	
	2007	<b>85,956</b>	<b>11</b>	
	2008	<b>87,217</b>	<b>12</b>	
<b>THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON</b>				
<b>105% OF THE PRIOR YEAR REAL ESTATE TAX BILL</b>				
<b>THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL</b>				
		<b>FOR BHF USE ONLY</b>		
	<b>13</b>	FROM R. E. TAX STATEMENT FOR 2008	\$	<b>13</b>
	<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
	<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
	<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**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.**



4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>87,217.38</u>	\$ <u>87,217.38</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 and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

**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:

01/01/2009 Ending:

12/31/2009

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

Facility Name &amp; ID Number MCKINLEY COURT

# 0042499

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

## 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	\$	\$ 2,209,175	4	
5		1997		10,762	391	27.5	391		4,876	5	
6		1998		95,000	3,455	27.5	3,455		41,311	6	
7										7	
8										8	
Improvement Type**											
9	RELATED PARTY - MCKINLEY AVE, LLC										9
10	OUTDOOR SIGNS										10
11	REPLACE, REPAIR AND SEAL PAVEMENT										11
12	REPLACE BLACK VALLEYS										12
13	WALLCOVERING/CARPETING/WINDOW TREATMENTS										13
14	SPRINKLER SYSTEM										14
15	COURTYARD IMPROVEMENTS										15
16	RESIDENT ROOMS/BATHROOMS - PAINTING										16
17	FIRE ALARM CONTROL PANEL										17
18	REMODELING - ARCHITECT FEE										18
19	PAINTING - S/E CORRIDOR/SMOKING RM/NURSES STATION										19
20	REPLACED 2 YORK ROOFTOP HVAC UNITS										20
21	REMOVE & INSTALL 130 CUSTOM WINDOW TREATMENTS										21
22	STENCIL & COAT LANDING DOCK & WALKWAY										22
23	ROOF REPAIR - REPAIR AREA WITH BUCKLED SHEATING										23
24	PREPARE & RESURFACE NORTH PARKING LOT										24
25	DRAPES, CURTAINS, BORDERS -SOUTH CORRIDOR										25
26	PREP, PAINT, HANG WALLCOVERINGS & BORDERS-PATIENT RM										26
27	DRAPES, CURTAINS, BORDERS & SIGNS - LOBBY, BEAUTY SHOP										27
28	BOARD FOR BEHIND THE HANDRAILS-FRONT LOBBY										28
29	LIGHTING FIXTURES AROUND THE OUTSIDE OF THE BLDG										29
30	DRAPES, VALANCE, RODS & HANDRAILS - PATIENT RMS										30
31	OAK UNFINISHED CABINETS AND BAY WINDOW TREATMENT										31
32	PREP & PAINT 26 BATHROOMS AFTER WALLPAPER REMOVAL										32
33	REMOVE & DISPOSE ROOF BEHIND AIR CONDITIONER										33
34	LAMINATED COUNTERTOP & SOLID SURFACE COUNTERS										34
35	FURNITURE STORAGE WHILE REMODELING										35
36	WIDEN TURNING RADIUS; PAVE PARKING LOAT 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 &amp; ID Number MCKINLEY COURT

# 0042499

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

## 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	\$ 944	15	\$ 1,005	\$ 61	\$ 6,717	37
38	INSTALL VINYL SHEET FLOORING - CARPET HALLS	2004	82,244	7,365	10	8,216	851	72,043	38
39	PAINT AND PATCH 30 PATIENT ROOMS	2005	8,000	803	10	803		5,989	39
40	TWO ROOF TOP UNITS	2005	11,720	426	27.5	426		1,758	40
41	REPLACEMENT WINDOWS	2006	958	35	27.5	35		123	41
42	2 NEW ROOFTOP UNITS	2006	12,994	473	27.5	473		1,555	42
43	2 ASSISTANT SHOWER ROOMS	2006	8,880	323	27.5	323		1,009	43
44	TILES - NORTH NURSE'S STATION	2007	4,079	148	27.5	148		445	44
45	FLOOR MATERIALS FOR SOUTH NURSE'S STATION	2007	8,241	300	27.5	300		899	45
46	FIRE ALARM PANEL	2007	2,981	108	27.5	108		316	46
47	REMODEL EAST NURSES STATION	2007	6,925	252	27.5	252		734	47
48	INSTALL 4 THRESHOLDS FOR SOUTH CRDR-NURSE STATI	2007	1,119	41	27.5	41		115	48
49	ROOF REPAIR	2007	6,200	225	27.5	225		582	49
50	CUBICLE CURTAINS	2007	10,513	701	27.5	701		1,811	50
51	85 GALLON WATER HEATER AND COOLER DOOR	2007	10,769	392	27.5	392		1,012	51
52	CARPET FOR ADMINISTRATIVE OFFICE	2007	1,060	106	10	106		247	52
53	SEALING AND ASPHALT - ENTIRE PARKING LOT	2007	19,930	1,993	10	1,993		4,650	53
54	ROOFING & GUTTERS	2007	3,580	130	27.5	130		260	54
55	PREP. & PAINT - 55 ROOMS, HALLWAYS, KITCHEN CEILIN	2008	15,319	1,532	10	1,532		2,809	55
56	INSTALL POWER EXHAUST FAN IN EXISTING DUCTWORK	2008	3,925	143	27.5	143		238	56
57	PAINT - DINING ROOM, BATHROOMS, & 57 PATIENT RMS	2008	2,445	245	10	245		326	57
58	REFLASH 2 AC UNITS IN EXISTING SHINGLE ROOF	2008	3,899	142	27.5	142		165	58
59	REPAIR, PATCH, REFINISH & PAINT - MAIN DINING ROOM	2009	6,430	54	10	54		54	59
60	INSTALL DRY PEND. SPRINKLERS IN KITCHEN AREA	2009	2,125		27.5				60
61	REPLACE ROOF TOP UNITS - KITCHEN & DINING AREA	2009	23,600	215	27.5	215		215	61
62									62
63			ADJ. TO SL	2,406			(2,406)		63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,464,298	\$ 215,408		\$ 215,408	\$	\$ 2,572,141	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	\$ 708,970	\$ 32,765	\$ 63,213	\$ 30,448	3-10 YRS	\$ 405,392	71
72	Current Year Purchases	116,838	63,179	5,842	(57,337)	3-10 YRS	5,842	72
73	Fully Depreciated Assets	48,551				3-10 YRS	48,551	73
74	RELATED PARTY		4,345	4,345				74
75	TOTALS	\$ 874,359	\$ 100,289	\$ 73,400	\$ (26,889)		\$ 459,785	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)		\$ 6,338,657	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 315,697	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 288,808	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$ (26,889)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 3,031,926	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	RENOVATION OF TPY RM	\$ 14,480	92
93			93
94			94
95		\$ 14,480	95

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

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

Facility Name & ID Number MCKINLEY COURT

# 0042499

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

**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	<b>TOTAL</b>				\$			7

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. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

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: \$ 40,710 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	<u>FACILITY</u>	<u>FORD E350 2009 BUS</u>	\$	\$ <u>15,935</u>	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$ <u>15,935</u>	21

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

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2009 Ending: 12/31/2009  
**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><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

- (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	1 Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 262,986	\$		\$ 262,986	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			73,388			73,388	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			306,515			306,515	4
5	Physician Care		visits							5
6	Dental Care	39-3	visits			2,496			2,496	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				338,205		338,205	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					84,807		84,807	13
14	<b>TOTAL</b>			\$		\$ 645,385	\$ 423,012		\$ 1,068,397	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: **01/01/2009**

Ending:

**12/31/2009**

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2009**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 103,291	\$ 534,565	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,647,714	1,647,714	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,224	127,983	6
7	Other Prepaid Expenses	58,181	58,181	7
8	Accounts Receivable (owners or related parties)	3,807,974	3,360,873	8
9	Other(specify): <b>ESCROW DEPOSITS</b>		938,991	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 5,652,384	\$ 6,668,307	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,351	1,351	12
13	Land		827,400	13
14	Buildings, at Historical Cost		5,464,297	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	874,359	874,359	16
17	Accumulated Depreciation (book methods)	(787,375)	(3,357,108)	17
18	Deferred Charges		118,866	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): <b>CONST. IN PROGRESS</b>		14,480	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 88,335	\$ 3,943,645	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,740,719	\$ 10,611,952	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 490,721	\$ 585,762	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	38,445	38,445	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	124,123	124,123	30
31	Accrued Taxes Payable (excluding real estate taxes)	27,281	27,281	31
32	Accrued Real Estate Taxes(Sch.IX-B)		91,600	32
33	Accrued Interest Payable	141,719	174,658	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<b>DUE TO LESSOR/PRIOR OWNER</b>			36
37	<b>MANAGEMENT FEES</b>	353,254	353,254	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,175,543	\$ 1,395,123	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	3,221,259	1,178,827	39
40	Mortgage Payable		5,934,978	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,221,259	\$ 7,113,805	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 4,396,802	\$ 8,508,928	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,343,917	\$ 2,103,024	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,740,719	\$ 10,611,952	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 130,125	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ.	3	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 130,128	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	1,213,789	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,213,789	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,343,917	24 *

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

Facility Name & ID Number **MCKINLEY COURT**# **0042499**Report Period Beginning: **01/01/2009**Ending: **12/31/2009**

**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		
<b>A. Inpatient Care</b>				
1	Gross Revenue -- All Levels of Care	\$ 9,928,400	1	
2	Discounts and Allowances for all Levels	( )	2	
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,928,400	3	
<b>B. Ancillary Revenue</b>				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8	
<b>C. Other Operating Revenue</b>				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop	1,127	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,127	23	
<b>D. Non-Operating Revenue</b>				
24	Contributions		24	
25	Interest and Other Investment Income***	7,274	25	
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 7,274	26	
<b>E. Other Revenue (specify):****</b>				
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27	
28	<b>VENDING COMMISSIONS</b>	600	28	
28a			28a	
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 600	29	
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,937,401	30	

		2		
Expenses		Amount		
<b>A. Operating Expenses</b>				
31	General Services	1,422,526	31	
32	Health Care	2,778,808	32	
33	General Administration	2,419,312	33	
<b>B. Capital Expense</b>				
34	Ownership	925,456	34	
<b>C. Ancillary Expense</b>				
35	Special Cost Centers	1,068,397	35	
36	Provider Participation Fee	82,125	36	
<b>D. Other Expenses (specify):</b>				
37	<b>OUT-OF-PERIOD EXPENSES</b>	26,988	37	
38			38	
39			39	
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,723,612	40	
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,213,789	41	
42	<b>Income Taxes</b>		42	
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,213,789	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: **01/01/2009**

Ending:

**12/31/2009**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,782	1,871	\$ 60,108	\$ 32.13	1
2	Assistant Director of Nursing	80	208	5,861	28.18	2
3	Registered Nurses	8,037	8,626	209,080	24.24	3
4	Licensed Practical Nurses	37,943	41,038	962,153	23.45	4
5	CNAs & Orderlies	71,998	77,559	859,746	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,806	4,290	51,061	11.90	8
9	Activity Director	3,236	3,478	57,520	16.54	9
10	Activity Assistants	5,145	5,590	55,923	10.00	10
11	Social Service Workers	1,808	2,085	25,242	12.11	11
12	Dietician					12
13	Food Service Supervisor	3,666	4,190	58,793	14.03	13
14	Head Cook	7,040	7,829	75,600	9.66	14
15	Cook Helpers/Assistants	11,304	11,675	95,258	8.16	15
16	Dishwashers					16
17	Maintenance Workers	4,395	4,874	87,940	18.04	17
18	Housekeepers	17,055	18,542	197,946	10.68	18
19	Laundry	16,446	17,905	153,007	8.55	19
20	Administrator	2,765	2,851	127,625	44.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,921	2,134	43,936	20.59	23
24	Clerical	8,207	8,744	159,808	18.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,762	4,118	54,108	13.14	31
32	Other Health C: <b>CLERICAL</b>	4,234	4,518	102,092	22.60	32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>214,630</b>	<b>232,125</b>	<b>\$ 3,442,807 *</b>	<b>\$ 14.83</b>	<b>34</b>

\* 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	196	\$ 10,387	1-3	35
36	Medical Director	96	30,000	9-3	36
37	Medical Records Consultant	10	1,215	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	4	150	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	54	3,286	11-3	44
45	Social Service Consultant	50	2,912	12-3	45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>	<b>947</b>	<b>\$ 135,667</b>		<b>49</b>

**C. CONTRACT NURSES**

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

Facility Name & ID Number **MCKINLEY COURT**

# **0042499**

Report Period Beginning: **01/01/2009**

Ending: **12/31/2009**

**XIX. SUPPORT SCHEDULES**

<b>A. Administrative Salaries</b>			<b>Ownership</b>	<b>Amount</b>	<b>D. Employee Benefits and Payroll Taxes</b>			<b>F. Dues, Fees, Subscriptions and Promotions</b>	
<b>Name</b>	<b>Function</b>	<b>%</b>		<b>Description</b>	<b>Amount</b>	<b>Description</b>	<b>Amount</b>		<b>Amount</b>
SONJA MILLER	ADMINISTRATOR		\$ 110,328	Workers' Compensation Insurance	\$ 77,874	IDPH License Fee	\$		
KIMBERLY JORDAN	ADMINISTRATOR		17,297	Unemployment Compensation Insurance	90,534	Advertising: Employee Recruitment			4,177
			0	FICA Taxes	253,991	Health Care Worker Background Check			1,200
				Employee Health Insurance	174,753	(Indicate # of checks performed <b>119</b> )			
				Employee Meals	0	Patient Background Checks	380		3,800
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC			5,400
				EMPLOYEE BENEFITS - OTHER	9,341	MARKETING/ADV/PROMO			112,237
				EMPLOYEE PHYSICAL EXAMS	2,642	LICENSES/DUES/SUBSCRIPTIONS			27,162
				PENSION/PROFIT SHARING PLANS	16,190	MGMT CO ALLOC			865
				CHICAGO HEAD TAX	0	TRUST/FRANCHISE/CONTRIB/ETC			(5,400)
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense			(65,676)
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising			(38,959)
						Yellow page advertising			(7,602)
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 127,625</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>	<b>\$ 625,325</b>	<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>			<b>\$ 37,204</b>
(List each licensed administrator separately.)									
<b>B. Administrative - Other</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			<b>G. Schedule of Travel and Seminar**</b>		
<b>Description</b>			<b>Amount</b>	<b>Description</b>	<b>Line #</b>	<b>Amount</b>	<b>Description</b>	<b>Amount</b>	
YORK ASSOCIATES, LLC	MANAGEMENT FEES		\$ 192,702				Out-of-State Travel	\$	
CHESTERFIELD, LLC	MANAGEMENT FEES		192,702						
							In-State Travel		
							TRAVEL		123
							RELATED PARTY		9,536
							Seminar Expense		7,196
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 385,404</b>	<b>TOTAL</b>		<b>\$</b>	Entertainment Expense	(	
(Attach a copy of any management service agreement)							(agree to Sch. V, line 24, col. 8)		
<b>C. Professional Services</b>							<b>TOTAL</b>		
<b>Vendor/Payee</b>	<b>Type</b>		<b>Amount</b>				<b>\$ 16,855</b>		
			\$						
<b>SEE SCHEDULE ATTACHED</b>			<b>423,685</b>						
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 423,685</b>						
(If total legal fees exceed \$5,000, attach copy of invoices.)									

\* 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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	\$ 2,063	3	\$ 344	\$ 688	\$ 688	\$ 343	\$	\$	\$	\$	\$
2												
3												
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16												
17												
18												
19												
20	<b>TOTALS</b>	\$ 2,063		\$ 344	\$ 688	\$ 688	\$ 343	\$	\$	\$	\$	\$

Facility Name &amp; ID Number MCKINLEY COURT

# 0042499

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

## 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 - \$11700
- (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. \$ 8,000 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: \_\_\_\_\_
- (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.