		FOR BHF USE			

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2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

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

I. IDPH License ID Number: 0042499

Facility Name: MCKINLEY COURT

Address: 500 WEST MCKINLEY AVENUE (Number) DECATUR (City) 62526 (Zip Code)

County: MACON

Telephone Number: (217) 875-0020 **Fax #** (217) 875-0647

HFS ID Number:

Date of Initial License for Current Owners: 02/01/1997

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: MICHAEL C. BRAUN Telephone Number: (847) 583-0100 X 126
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) (Date)
	(Type or Print Name) MICHAEL C. BRAUN
	(Title) CONTROLLER
Paid Preparer	(Signed) (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	763	343	10,667	11,773	8
9	SNF/PED					9
10	ICF	26,122	11,731	928	38,781	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,885	12,074	11,595	50,554	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.34%

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 [X]

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

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 [x] Date 02/01/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 150 and days of care provided 10,640

Medicare Intermediary WPS (WISCONSIN PHYSICIANS SERVICES)

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	265,212	52,019	17,352	334,583		334,583	(4,127)	330,456			1
2	Food Purchase		312,883		312,883		312,883	(4,014)	308,869			2
3	Housekeeping	231,008	59,050		290,058		290,058	5,511	295,569			3
4	Laundry	164,693	46,863	1,577	213,133		213,133	(1,269)	211,864			4
5	Heat and Other Utilities			171,037	171,037		171,037		171,037			5
6	Maintenance	94,737	65,224	81,544	241,505		241,505	(4,058)	237,447			6
7	Other (specify):*			34,466	34,466		34,466		34,466			7
8	**TOTAL General Services**	755,650	536,039	305,976	1,597,665		1,597,665	(7,957)	1,589,708			8
	B. Health Care and Programs											
9	Medical Director			30,000	30,000		30,000		30,000			9
10	Nursing and Medical Records	2,670,673	175,023	88,546	2,934,242		2,934,242	(90,944)	2,843,298			10
10a	Therapy	27,839			27,839		27,839		27,839			10a
11	Activities	113,369	15,048	24,864	153,281		153,281	902	154,183			11
12	Social Services	39,757		13,181	52,938		52,938		52,938			12
13	CNA Training											13
14	Program Transportation			1,872	1,872		1,872		1,872			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,851,638	190,071	158,463	3,200,172		3,200,172	(90,042)	3,110,130			16
	C. General Administration											
17	Administrative	101,185		391,434	492,619		492,619	(399,575)	93,044			17
18	Directors Fees											18
19	Professional Services			454,186	454,186		454,186	(220,152)	234,034			19
20	Dues, Fees, Subscriptions & Promotions			152,822	152,822		152,822	(112,190)	40,632			20
21	Clerical & General Office Expenses	251,889	45,660	75,055	372,604		372,604	207,539	580,143			21
22	Employee Benefits & Payroll Taxes			714,898	714,898		714,898		714,898			22
23	Inservice Training & Education			4,698	4,698		4,698		4,698			23
24	Travel and Seminar			384	384		384	10,069	10,453			24
25	Other Admin. Staff Transportation			13,174	13,174		13,174		13,174			25
26	Insurance-Prop.Liab.Malpractice			380,465	380,465		380,465	3,870	384,335			26
27	Other (specify):*			195,102	195,102		195,102	(195,102)				27
28	**TOTAL General Administration**	353,074	45,660	2,382,218	2,780,952		2,780,952	(705,541)	2,075,411			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,960,362	771,770	2,846,657	7,578,789		7,578,789	(803,540)	6,775,249			29

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

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

Facility Name & ID#: MCKINLEY COURT #0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,847	
	REPAIRS & MAINTENANCE		5,505	
			0	17,352
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,577	
			0	1,577
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		52,463	
	ELECTRICITY		104,087	
	WATER		14,487	
	CABLE TV - LOBBY		0	
			0	171,037
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,440	
	PAINTING & DECORATING		6,559	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		44,918	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		9,132	
	FIRE SERVICE		16,495	
			0	
			0	
			0	
			0	81,544
7	**OTHER**			
	SCAVENGER		34,466	
	SECURITY SERVICE		0	
			0	
			0	34,466
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 CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,577	
	PHARMACY CONSULTANT	XVIII B 39-2	7,662	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	79,307	
			0	
			0	88,546
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 CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		21,708	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,156	
			0	24,864
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES			
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	13,181	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	13,181
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MCKINLEY COURT #0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,872	1,872
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	391,434	391,434
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	27,416	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	426,770	
			0	454,186
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	74,758	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	20,583	
	EMPLOYEE WANT ADS	XIX F	8,335	
	CONTRIBUTIONS	VI 20 XIX F	1,380	
	DUES & SUBSCRIPTIONS	XIX F	26,112	
	LICENSES & PERMITS	XIX F	2,958	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	8,937	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	7,257	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	620	
	PATIENT BACKGROUND CHECKS	XIX F	1,882	
				152,822
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		6,128	
	EQUIPMENT REPAIR & MAINTENANCE		275	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	5,651	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		3,722	
	TELEPHONE		55,721	
	MESSENGER SERVICE		3,558	
			0	75,055

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	291,708	
	UNEMPLOYMENT COMPENSATION	XIX D	111,638	
	WORKERS COMPENSATION INSURANC	XIX D	74,097	
	HOSPITALIZATION INSURANCE	XIX D	203,164	
	EMPLOYEE BENEFITS - OTHER	XIX D	17,381	
	EMPLOYEE PHYSICAL EXAMS	XIX D	1,518	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	15,392	
	CHICAGO HEAD TAX	XIX D	0	
			0	714,898
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,698	
				4,698
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	384	
				384
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		13,174	
				13,174
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		380,465	
				380,465
27	**OTHER**			
	BAD DEBTS	VI 24	195,102	
				195,102

GRAND TOTAL COLUMN 3 OTHER **2,846,657**

MCKINLEY COURT
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	312,883
LESS SALES TAX	(4,014)
NET FOOD	308,869
TOTAL PATIENT CENSUS	50,554
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	151,662
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	151,662
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	151,662
NET FOOD	308,869
DIVIDE TOTAL MEALS/YEAR	151,662
COST PER MEAL	2.04
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number MCKINLEY COURT #0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			129,600	129,600		129,600	177,590	307,190			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			64,202	64,202		64,202	395,954	460,156			32
33	Real Estate Taxes			87,223	87,223		87,223		87,223			33
34	Rent-Facility & Grounds			576,000	576,000		576,000	(529,371)	46,629			34
35	Rent-Equipment & Vehicles			60,831	60,831		60,831	9,050	69,881			35
36	Other (specify):* STORAGE/MTG INS			8,767	8,767		8,767	29,463	38,230			36
37	TOTAL Ownership			926,623	926,623		926,623	82,686	1,009,309			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		377,850	830,325	1,208,175		1,208,175		1,208,175			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			82,125	82,125		82,125		82,125			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		377,850	912,450	1,290,300		1,290,300		1,290,300			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,960,362	1,149,620	4,685,730	9,795,712		9,795,712	(720,854)	9,074,858			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: 01/01/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(49,242)	30		9
10	Interest and Other Investment Income	(1,016)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,014)	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	(5,651)	21		18
19	Entertainment	(74,758)	20		19
20	Contributions	(8,637)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(13,673)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(195,102)	27		24
25	Fund Raising, Advertising and Promotional	(20,583)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(8,937)	20		28
29	Other-Attach Schedule	(85,445)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (467,058)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(253,796)	PG 6-6D	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (253,796)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (720,854)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		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: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	VACATION ACCRUAL	(4,127)	1	2
3	VACATION ACCRUAL	5,511	3	3
4	VACATION ACCRUAL	(1,269)	4	4
5	VACATION ACCRUAL	(4,058)	6	5
6	VACATION ACCRUAL	(52,828)	10	6
7	VACATION ACCRUAL	902	11	7
8	VACATION ACCRUAL	(8,141)	17	8
9	VACATION ACCRUAL	(12,755)	21	9
10	MEDICARE A CONSULTANT	(2,000)	19	10
11	MEDICARE A BILLING		19	11
12	MARKETING CONSULTANT	(6,680)	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	(85,445)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(4,127)	0	0	0	0	0	0	0	0	0	0	(4,127)	1
2	Food Purchase	(4,014)	0	0	0	0	0	0	0	0	0	0	(4,014)	2
3	Housekeeping	5,511	0	0	0	0	0	0	0	0	0	0	5,511	3
4	Laundry	(1,269)	0	0	0	0	0	0	0	0	0	0	(1,269)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,058)	0	0	0	0	0	0	0	0	0	0	(4,058)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(7,957)	0	0	0	0	0	0	0	0	0	0	(7,957)	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	(52,828)	0	0	(38,116)	0	0	0	0	0	0	0	(90,944)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	902	0	0	0	0	0	0	0	0	0	0	902	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	(51,926)	0	0	(38,116)	0	0	0	0	0	0	0	(90,042)	16
	C. General Administration													
17	Administrative	(8,141)	0	(195,717)	0	0	(195,717)	0	0	0	0	0	(399,575)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(22,353)	32,135	35,797	2,464	(268,195)	0	0	0	0	0	0	(220,152)	19
20	Fees, Subscriptions & Promotions	(112,915)	250	123	77	275	0	0	0	0	0	0	(112,190)	20
21	Clerical & General Office Expenses	(18,406)	0	27,569	5,545	192,831	0	0	0	0	0	0	207,539	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	4,263	5,806	0	0	0	0	0	0	10,069	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	895	1,788	1,187	0	0	0	0	0	0	3,870	26
27	Other (specify):*	(195,102)	0	0	0	0	0	0	0	0	0	0	(195,102)	27
28	TOTAL General Administration	(356,917)	32,385	(131,333)	14,137	(68,096)	(195,717)	0	0	0	0	0	(705,541)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(416,800)	32,385	(131,333)	(23,979)	(68,096)	(195,717)	0	0	0	0	0	(803,540)	29

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(49,242)	222,798	178	829	3,027	0	0	0	0	0	0	177,590	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,016)	396,970	0	0	0	0	0	0	0	0	0	395,954	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	1,508	45,121	0	0	0	0	0	0	(529,371)	34
35	Rent-Equipment & Vehicles	0	0	3,540	4,183	1,327	0	0	0	0	0	0	9,050	35
36	Other (specify):*	0	29,463	0	0	0	0	0	0	0	0	0	29,463	36
37	TOTAL Ownership	(50,258)	73,231	3,718	6,520	49,475	0	0	0	0	0	0	82,686	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)	(467,058)	105,616	(127,615)	(17,459)	(18,621)	(195,717)	0	0	0	0	0	(720,854)	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		SEE ATTACHED LIST OF RELATED		MCKINLEY AVE, LLC		
OWNERS		NURSING HOMES			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. [X] 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		" "		29,463	29,463	2
3	V	30	DEPRECIATION - BLDG/IMP		" "		222,798	222,798	3
4	V	30	DEPRECIATION - EQPT		" "				4
5	V	32	AMORTIZATION - MTG COST		" "		4,349	4,349	5
6	V	32	INTEREST - MORTGAGE		" "		392,621	392,621	6
7	V	19	OTHER PROFESSIONAL		" "		10,000	10,000	7
8	V	19	ACCOUNTING FEES		" "		22,085	22,085	8
9	V	19	DATA PROCESSING		" "		50	50	9
10	V	20	DUES & SUBSCRIPTIONS		" "		250	250	10
11	V								11
12	V								12
13	V								13
14	Total			$ 576,000			$ 681,616	$ * 105,616	14

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 56,408	YORK MANAGEMENT ASSOCIATION, LLC		$ 92,205	$ 35,797	15
16	V	20	DUES & SUBSCRIPTIONS		" "		123	123	16
17	V	21	CLERICAL		" "		27,569	27,569	17
18	V	24	TRAVEL		" "				18
19	V	26	INSURANCE		" "		895	895	19
20	V	35	RENT - EQPT & VEH		" "		3,540	3,540	20
21	V	17	ADMINISTRATION	195,717	" "			(195,717)	21
22	V	30	DEPRECIATION		" "		178	178	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			$ 252,125			$ 124,510	$ * (127,615)	39

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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	$ 79,307	CARLYLE NURSING ASSOCIATES, LLC		$ 41,191	$ (38,116)	15
16	V	19	PROFESSIONAL FEES		" "		2,464	2,464	16
17	V	20	DUES & SUBSCRIPTIONS		" "		77	77	17
18	V	21	CLERICAL		" "		5,545	5,545	18
19	V	24	TRAVEL		" "		4,263	4,263	19
20	V	26	INSURANCE		" "		1,788	1,788	20
21	V	30	DEPRECIATION		" "		829	829	21
22	V	34	RENT		" "		1,508	1,508	22
23	V	35	RENT - EQPT & VEH		" "		4,183	4,183	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			$ 79,307			$ 61,848	$ * (17,459)	39

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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		$ 1,709	$ (268,195)	15
16	V	20	DUES & SUBSRIPTIONS		" "		275	275	16
17	V	21	CLERICAL		" "		192,831	192,831	17
18	V	24	TRAVEL		" "		5,806	5,806	18
19	V	26	INSURANCE		" "		1,187	1,187	19
20	V	30	DEPRECIATION		" "		3,027	3,027	20
21	V	34	RENT		" "		45,121	45,121	21
22	V	35	RENT - EQPT & VEH		" "		1,327	1,327	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			$ 269,904			$ 251,283	$ * (18,621)	39

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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. [X] 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	$ 195,717	CHESTERFIELD, LLC		$	$ (195,717)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 195,717			$ 0	$ * (195,717)	39

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
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: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	191,162	4	$ 348,655	$	50,554	$ 92,205	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	191,162	4	466		50,554	123	2
3	21	CLERICAL	PATIENT DAYS	191,162	4	3,883		50,554	1,027	3
4	24	TRAVEL	PATIENT DAYS	191,162	4			50,554	0	4
5	26	INSURANCE	PATIENT DAYS	191,162	4	3,386		50,554	895	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	191,162	4	13,387		50,554	3,540	6
7	21	CLERICAL	DIRECT HOURS	1	1	26,542	26,542	1	26,542	7
8	30	DEPRECIATION	PATIENT DAYS	191,162	4	674		50,554	178	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					$ 396,993	$ 26,542		$ 124,510	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 X 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT HOURS	1	1	$ 41,191	$ 41,191	1	$ 41,191	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	552,974	11	26,955		50,554	2,464	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,974	11	842		50,554	77	3
4	21	CLERICAL	PATIENT DAYS	552,974	11	60,665		50,554	5,545	4
5	24	TRAVEL	PATIENT DAYS	552,974	11	46,637		50,554	4,263	5
6	26	INSURANCE	PATIENT DAYS	552,974	11	19,567		50,554	1,788	6
7	30	DEPRECIATION	PATIENT DAYS	552,974	11	9,065		50,554	829	7
8	34	RENT	PATIENT DAYS	552,974	11	16,500		50,554	1,508	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	552,974	11	45,767		50,554	4,183	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					$ 267,189	$ 41,191		$ 61,848	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	552,954	11	$ 18,688	$	50,554	$ 1,709	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	552,954	11	3,004		50,554	275	2
3	21	CLERICAL	PATIENT DAYS	552,954	11	200,775		50,554	18,356	3
4	24	TRAVEL	PATIENT DAYS	552,954	11	63,497		50,554	5,806	4
5	26	INSURANCE	PATIENT DAYS	552,954	11	12,980		50,554	1,187	5
6	30	DEPRECIATION	PATIENT DAYS	552,954	11	33,106		50,554	3,027	6
7	34	RENT	PATIENT DAYS	552,954	11	493,503		50,554	45,121	7
8	35	RENT -EQPT & VEH	PATIENT DAYS	552,954	11	14,513		50,554	1,327	8
9	21	CLERICAL	DIRECT HOURS	1	1	174,475	174,475	1	174,475	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,014,541	$ 174,475		$ 251,283	25

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	BERKADIA		X	MORTGAGE	$39,218.00	07/2002	6,375,000	5,857,290	07/2037	6.6600	392,621	2
3	LOAN COSTS		X	LOAN COSTS	AMORT - 35 YEARS		152,161	114,517			4,349	3
4												4
5												5
	Working Capital											
6	RELATED PARTIES	X		WORKING CAPITAL	VARIES	12/99	475,000	3,466,259	DEMAND	VARIES	63,365	6
7	LETTER OF CREDIT FEE		X								837	7
8												8
9	TOTAL Facility Related				$39,218.00		$ 7,002,161	$ 9,438,066			$ 461,172	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,002,161	$ 9,438,066			$ 461,172	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2009 report.	$	91,600	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.)	$	88,923	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,677)	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	89,900	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.	$	87,223	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	81,438	8
2006	82,847	9
2007	85,956	10
2008	87,217	11
2009	88,923	12

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 2009 TAX BILL.

	FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2009	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MCKINLEY COURT COUNTY MACON

FACILITY IDPH LICENSE NUMBER 0042499

CONTACT PERSON REGARDING THIS REPORT MICHAEL BRAUN

TELEPHONE (847) 583-0100 X 126 FAX #: (847) 583-8873

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-015	NURSING HOME	$ 88,922.66	$ 88,922.66
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 88,922.66	$ 88,922.66

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

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 [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	119,700	1997	$	1
2					2
3	TOTALS	119,700		$	3

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1997		$ 4,688,282	$ 170,483	27.5	$ 170,483	$	$ 2,379,658	4
5			1997		10,762	391	27.5	391		5,267	5
6			1998		95,000	3,454	27.5	3,454		44,765	6
7											7
8											8
	Improvement Type**										
9	*****RELATED PARTY - MCKINLEY AVE, LLC*************										9
10	OUTDOOR SIGNS			1997	13,284	483	27.5	483		6,501	10
11	REPLACE, REPAIR AND SEAL PAVEMENT			1998	6,754	399	15	450	51	5,860	11
12	REPLACE BLACK VALLEYS			1999	5,875	214	27.5	214		2,448	12
13	WALLCOVERING/CARPETING/WINDOW TREATMENTS			1999	154,975	5,636	27.5	5,636		64,573	13
14	SPRINKLER SYSTEM			1999	4,744	173	27.5	173		1,977	14
15	COURTYARD IMPROVEMENTS			2000	5,975	352	15	398	46	4,478	15
16	RESIDENT ROOMS/BATHROOMS - PAINTING			2000	13,710	499	27.5	499		5,214	16
17	FIRE ALARM CONTROL PANEL			2000	6,703	244	27.5	244		2,549	17
18	REMODELING - ARCHITECT FEE			2000	1,493	88	15	99	11	1,119	18
19	PAINTING - S/E CORRIDOR/SMOKING RM/NURSES STATION			2001	7,382	268	27.5	268		2,539	19
20	REPLACED 2 YORK ROOFTOP HVAC UNITS			2003	11,340	413	27.5	413		3,076	20
21	REMOVE & INSTALL 130 CUSTOM WINDOW TREATMENTS			2003	19,732	717	27.5	717		5,351	21
22	STENCIL & COAT LANDING DOCK & WALKWAY			2003	4,397	160	27.5	160		1,193	22
23	ROOF REPAIR - REPAIR AREA WITH BUCKLED SHEATING			2003	2,000	72	27.5	72		542	23
24	PREPARE & RESURFACE NORTH PARKING LOT			2003	5,120	187	27.5	187		1,389	24
25	DRAPES, CURTAINS, BORDERS - SOUTH CORRIDOR			2004	21,455	1,914	10	2,146	232	20,959	25
26	PREP, PAINT, HANG WALLCOVERINGS & BORDERS-PATIENT RM			2004	58,800	5,248	10	5,880	632	57,440	26
27	DRAPES, CURTAINS, BORDERS & SIGNS -LOBBY, BEAUTY SHOP			2004	14,052	1,254	10	1,405	151	13,727	27
28	BOARD FOR BEHIND THE HANDRAILS-FRONT LOBBY			2004	1,585	58	27.5	58		387	28
29	LIGHING FIXTURES AROUND THE OUTSIDE OF THE BLDG			2004	3,335	121	27.5	121		793	29
30	DRAPES, VALANCE, RODS & HANDRAILS - PATENT RMS			2004	12,350	1,103	10	1,235	132	12,064	30
31	OAK UNFINISHED CABINETS AND BAY WINDOW TREATMENT			2004	1,578	140	10	157	17	1,541	31
32	PREP & PAINT 26 BATHROOMS AFTER WALLPAPER REMOVAL			2004	3,800	339	10	380	41	3,712	32
33	REMOVE & DISPOSE ROOF BEHIND AIR CONDITIONER			2004	3,000	268	10	300	32	2,931	33
34	LAMINATED COUNTERTOP & SOLID SURFACE COUNTERS			2004	8,300	741	10	830	89	8,108	34
35	FURNITURE STORAGE WHILE REMODELING			2004	5,429	485	10	543	58	5,304	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: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALL SPEED BUMPS	2004	$ 15,150	$ 895	15	$ 1,010	$ 115	$ 7,727	37
38	INSTALL VINYL SHEET FLOORING - CARPET HALLS	2004	82,244	7,370	10	8,225	855	80,268	38
39	PAINT AND PATCH 30 PATIENT ROOMS	2005	8,000	698	10	800	102	6,789	39
40	TWO ROOF TOP UNITS	2005	11,720	426	27.5	426		2,184	40
41	REPLACEMENT WINDOWS	2006	958	35	27.5	35		158	41
42	2 NEW ROOFTOP UNITS	2006	12,994	473	27.5	473		2,028	42
43	2 ASSISTANT SHOWER ROOMS	2006	8,880	323	27.5	323		1,332	43
44	TILES - NORTH NURSES STATION	2007	4,079	148	27.5	148		593	44
45	FLOOR MATERIALS FOR SOUTH NURSES STATION	2007	8,241	300	27.5	300		1,199	45
46	FIRE ALARM PANEL	2007	2,981	109	27.5	109		425	46
47	REMODEL EAST NURSES STATION	2007	6,925	252	27.5	252		986	47
48	INSTALL 4 THRESHOLDS FOR SOUTH CRDR-NURSE STAT	2007	1,119	41	27.5	41		156	48
49	ROOF REPAIR	2007	6,200	226	27.5	226		808	49
50	CUBICLE CURTAINS	2007	10,513	700	27.5	700		2,511	50
51	85 GALLON WATER HEATER AND COOLER DOOR	2007	10,769	391	27.5	391		1,403	51
52	CARPET FOR ADMINISTRATIVE OFFICE	2007	1,060	106	10	106		353	52
53	SEALING AND ASPHALT - ENTIRE PARKING LOT	2007	19,930	1,993	10	1,993		6,643	53
54	ROOFING & GUTTERS	2007	3,580	131	27.5	131		391	54
55	PREP. & PAINT - 55 ROOMS, HALLWAYS, KITCHEN CEILIN	2008	15,319	1,531	10	1,531		4,340	55
56	INSTALL POWER EXHAUST FAN IN EXISTING DUCTWORI	2008	3,925	143	27.5	143		381	56
57	PAINT - DINING ROOM, BATHROOMS, & 57 PATIENT RMS	2008	2,445	245	10	245		571	57
58	REFLASH 2 AC UNITS IN EXISTING SHINGLE ROOF	2008	3,899	142	27.5	142		307	58
59	REPAIR, PATCH REFINISH & PAINT - MAIN DINING ROOM	2009	6,430	643	10	643		697	59
60	INSTALL DRY PEND. SPRINKLERS IN KITCHEN AREA	2009	2,125	77	27.5	77		77	60
61	REPLACE ROOF TOP UNITS - KITCHEN & DINING AREA	2009	23,600	858	27.5	858		1,073	61
62	COMMERCIAL VINYL FLOORING - KITCHEN	2010	9,548	333	27.5	333		333	62
63	REMOVE & INSTALL WALLPAPER, PAINT WOOD &								63
64	METAL TRIM, TILE KITCHEN FLOOR, FLOORING AND								64
65	WALLPAPER FOR PT ROOMS, CORRIDORS & RESTROOMS								65
66	INSTALL HANDICAP CURBING & HANDRAILS &								66
67	REINSTALL SIDEWALK	2010	75,437	2,400	27.5	2,400		2,400	67
68	COMMERCIAL VINYL FOR FLOORING & SPOOLS OF								68
69	BORDERS -CORRIDORS	2010	5,191	134	27.5	134		134	69
70	TOTAL (lines 4 thru 69)		$ 5,554,474	$ 217,027		$ 219,591	$ 2,564	$ 2,791,732	70

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,554,474	$ 217,027		$ 219,591	$ 2,564	$ 2,791,732	1
2	MATERIALS & LUMBER FOR PT ROOM	2010	6,010	155	27.5	155		155	2
3	REPLACE ALL HANDRAILS IN NORTH & MIDDLE								3
4	CORRIDOR	2010	13,859	357	27.5	357		357	4
5	PAINT LOBBY & CORRIDOR WALLS & ACTIVITY AREA								5
6	PAINT METAL DOOR FRAMES IN ACTIVITY AREA	2010	5,950	135	27.5	135		135	6
7	REPLACE DOOR IN NEW PT ROOM WITH THE ADDITION								7
8	OF A NEW WINDOW	2010	1,328	30	27.5	30		30	8
9	INSTALL NEW TUB, TOILET, DOORS & WINDOW IN PT RM	2010	14,613	332	27.5	332		332	9
10	REPLACE SHINGLES & ROOFING CEMENT AROUND ROO	2010	6,950	137	27.5	137		137	10
11	INSTALL NEW FAUCETS, TUB, & TOILET & REPLACE								11
12	FLOOR DRAIN	2010	4,487	75	27.5	75		75	12
13	RESURFACE LOADING DOCK, APPLY FIBER PATCH AND								13
14	FILL ALL VOIDS, INSTALL CEMENT FINISH & VERTICAL								14
15	WALLS	2010	21,823	364	27.5	364		364	15
16	HANDRAILS AND ENDCAPS FOR PT ROOM	2010	6,285	105	27.5	105		105	16
17	BEAUTY SHOP REMODELING - DEMOLISH FLOOR &								17
18	INSTALL NEW VCT FLOOR WITH CERAMIC TRIM, INSTL								18
19	NEW LIGHTING FIXTURES, LAMINATE FLOORING AND								19
20	COVEBASE	2010	7,225	99	27.5	99		99	20
21	PAVE PARKING LOT, PATCH & RESTRIPE PATCHED ARE	2010	26,902	1,345	15	1,345		1,345	21
22	PAINT FRONT OUTSIDE ENTRANCE, REPAINT CEILING &								22
23	COLUMNS, INSTL WOOD STRIPS, & FIRE RATED CEILING	2010	6,916	73	27.5	73		73	23
24									24
25			ADJ. TO SL	2,564			(2,564)		25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,676,822	$ 222,798		$ 222,798	$	$ 2,794,939	34

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 799,731	$ 38,158	$ 73,398	$ 35,240	3-10 YRS	$ 458,557	71
72	Current Year Purchases	139,192	91,442	6,960	(84,482)	3-10 YRS	6,960	72
73	Fully Depreciated Assets	74,626				3-10 YRS	74,626	73
74	RELATED PARTY		4,034	4,034				74
75	TOTALS	$ 1,013,549	$ 133,634	$ 84,392	$ (49,242)		$ 540,143	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)	$ 6,690,371	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 356,432	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 307,190	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (49,242)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,335,082	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	FIRE SPRINKLER SYSTEM	$ 60,000	92
93			93
94			94
95		$ 60,000	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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 46,092 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	FORD E350 2009 BUS	$	$ 14,739	17
18					18
19					19
20					20
21	TOTAL		$	$ 14,739	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: 01/01/2010 Ending: 12/31/2010

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 375,472	$		$ 375,472	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			78,131			78,131	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			373,780			373,780	4
5	Physician Care		visits							5
6	Dental Care		visits			2,942			2,942	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				270,602		270,602	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): X-RAY	39-2					107,248		107,248	13
14	TOTAL			$		$ 830,325	$ 377,850		$ 1,208,175	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: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 165,078	$ 576,295	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 313,484)	1,395,566	1,395,566	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,351	1,351	5
6	Prepaid Insurance	41,503	117,221	6
7	Other Prepaid Expenses	266,945	276,917	7
8	Accounts Receivable (owners or related parties)	696,398	11,421	8
9	Other(specify): ESCROW DEPOSITS		138,949	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,566,841	$ 2,517,720	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	3,207,733	3,207,733	11
12	Long-Term Investments			12
13	Land		827,400	13
14	Buildings, at Historical Cost		5,676,821	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,013,550	1,013,550	16
17	Accumulated Depreciation (book methods)	(916,975)	(3,706,942)	17
18	Deferred Charges		114,517	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		626,478	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CONST. IN PROGRESS		60,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,304,308	$ 7,819,557	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,871,149	$ 10,337,277	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 378,830	$ 392,830	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,925	25,925	28
29	Short-Term Notes Payable	258,339	258,339	29
30	Accrued Salaries Payable	153,759	153,759	30
31	Accrued Taxes Payable (excluding real estate taxes)	35,430	35,430	31
32	Accrued Real Estate Taxes(Sch.IX-B)		89,900	32
33	Accrued Interest Payable	141,719	32,508	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO LESSOR/PRIOR OWNER			36
37	DUE TO IDPA	58,129	58,129	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,052,131	$ 1,046,820	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,466,259	1,423,827	39
40	Mortgage Payable		5,857,290	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)**	$ 3,466,259	$ 7,281,117	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,518,390	$ 8,327,937	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,352,759	$ 2,009,340	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,871,149	$ 10,337,277	48

*(See instructions.)

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,343,917	1
2	Restatements (describe):		2
3			3
4	ROUNDING ADJ.	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,343,919	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	8,840	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)**	$ 8,840	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,352,759	24 *

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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,802,027	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,802,027	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	678	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 678	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,016	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,016	26
	E. Other Revenue (specify):*****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	NET VENDING COMMISSIONS	831	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 831	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,804,552	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,597,665	31
32	Health Care	3,200,172	32
33	General Administration	2,780,952	33
	B. Capital Expense		
34	Ownership	926,623	34
	C. Ancillary Expense		
35	Special Cost Centers	1,208,175	35
36	Provider Participation Fee	82,125	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,795,712	40
41	**Income before Income Taxes (line 30 minus line 40)****	8,840	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 8,840	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: 01/01/2010 Ending: 12/31/2010

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	2,377	2,586	$ 139,226	$ 53.84	1
2	Assistant Director of Nursing	195	199	6,417	32.25	2
3	Registered Nurses	9,939	10,447	277,492	26.56	3
4	Licensed Practical Nurses	36,288	39,572	1,003,282	25.35	4
5	CNAs & Orderlies	80,895	86,887	1,025,477	11.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,892	2,180	27,839	12.77	8
9	Activity Director	2,406	2,656	46,470	17.50	9
10	Activity Assistants	5,334	5,693	66,899	11.75	10
11	Social Service Workers	2,190	2,352	39,757	16.90	11
12	Dietician					12
13	Food Service Supervisor	4,932	5,541	77,665	14.02	13
14	Head Cook	7,846	8,592	85,362	9.94	14
15	Cook Helpers/Assistants	11,503	11,920	102,185	8.57	15
16	Dishwashers					16
17	Maintenance Workers	4,637	5,201	94,737	18.22	17
18	Housekeepers	18,687	20,385	231,008	11.33	18
19	Laundry	18,389	19,080	164,693	8.63	19
20	Administrator	2,056	2,508	101,185	40.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,316	13,120	251,889	19.20	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	9,471	10,559	218,779	20.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	230,353	249,478	$ 3,960,362 *	$ 15.87	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	206	$ 11,847	1-3	35
36	Medical Director	MONTHLY	30,000	9-3	36
37	Medical Records Consultant	32	1,577	10-3	37
38	Nurse Consultant	MONTHLY	79,307	10-3	38
39	Pharmacist Consultant	MONTHLY	7,662	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	48	3,156	11-3	44
45	Social Service Consultant	48	13,181	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	334	$ 146,730		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

Facility Name & ID Number MCKINLEY COURT # 0042499 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KIMBERLY JORDAN	ADMINISTRATOR		$ 101,185
	ASST ADMIN		0
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,185

B. Administrative - Other

Description		Amount
YORK ASSOCIATES, LLC	MANAGEMENT FEES	$ 195,717
CHESTERFIELD, LLC	MANAGEMENT FEES	195,717
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 391,434

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		454,186
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 454,186

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 74,097
Unemployment Compensation Insurance	111,638
FICA Taxes	291,708
Employee Health Insurance	203,164
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	17,381
EMPLOYEE PHYSICAL EXAMS	1,518
PENSION/PROFIT SHARING PLANS	15,392
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 714,898

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	8,335
Health Care Worker Background Check	620
(Indicate # of checks performed 62)	
Patient Background Checks 188	1,882
TRUST/FRANCHISE/CONTRIB/ETC	8,637
MARKETING/ADV/PROMO	104,278
LICENSES/DUES/SUBSCRIPTIONS	29,070
MGMT CO ALLOC	725
TRUST/FRANCHISE/CONTRIB/ETC	(8,637)
Less: Public Relations Expense	(74,758)
Non-allowable advertising	(20,583)
Yellow page advertising	(8,937)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,632

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	384
RELATED PARTY	10,069
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,453

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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. - $12847.50 /ILL. COUNCIL ON LTC - $9000**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? ______

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,251** 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 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.