FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0051821

Facility Name: McKinley Court

Address: 500 W McKinley Ave (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: 01/01/2012

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Amanda Springborn **Telephone Number:** (314) 925-3838
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 01/01/2014 to 12/31/2014 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address) McGladrey LLP, 20 N. Martingale Road, Ste. 500, Schaumburg, IL 60173
(Telephone) (847) 517-7070 Fax # (847) 517-7067

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 # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0	0	11,884	11,884	8
9	SNF/PED					9
10	ICF	26,766	7,983	738	35,487	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,766	7,983	12,622	47,371	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.52%

D. How many bed-hold days during this year were paid by the Department?
N/A (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 [X] NO [ ] Note : Non-allowable costs have been eliminated in Schedule V, Column 7.

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 01/01/2012

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/2011 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 10,603

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	299,933	51,768	11,019	362,720		362,720		362,720			1
2	Food Purchase		339,075		339,075		339,075		339,075			2
3	Housekeeping	268,145	56,527		324,672		324,672		324,672			3
4	Laundry	95,201	31,711	35	126,947		126,947		126,947			4
5	Heat and Other Utilities			125,036	125,036		125,036	581	125,617			5
6	Maintenance	63,128	80	167,847	231,055		231,055	5,352	236,407			6
7	Other (specify):*											7
8	**TOTAL General Services**	726,407	479,161	303,937	1,509,505		1,509,505	5,933	1,515,438			8
	B. Health Care and Programs											
9	Medical Director			65,640	65,640		65,640		65,640			9
10	Nursing and Medical Records	2,764,864	138,743	47,034	2,950,641		2,950,641	43,894	2,994,535			10
10a	Therapy	54,991			54,991		54,991		54,991			10a
11	Activities	89,627		17,707	107,334		107,334		107,334			11
12	Social Services	62,143		3,037	65,180		65,180		65,180			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Mgmt. Co. Benefits							8,769	8,769			15
16	**TOTAL Health Care and Programs**	2,971,625	138,743	133,418	3,243,786		3,243,786	52,663	3,296,449			16
	C. General Administration											
17	Administrative	106,739		534,092	640,831		640,831	(534,092)	106,739			17
18	Directors Fees											18
19	Professional Services			241,963	241,963		241,963	17,559	259,522			19
20	Dues, Fees, Subscriptions & Promotions			31,184	31,184		31,184	(2,088)	29,096			20
21	Clerical & General Office Expenses	350,463	35,638	89,555	475,656		475,656	179,989	655,645			21
22	Employee Benefits & Payroll Taxes			543,601	543,601		543,601		543,601			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,489	7,489		7,489	12,983	20,472			24
25	Other Admin. Staff Transportation			19,640	19,640		19,640		19,640			25
26	Insurance-Prop.Liab.Malpractice			290,142	290,142		290,142	7,252	297,394			26
27	Other (specify):*							25,550	25,550			27
28	**TOTAL General Administration**	457,202	35,638	1,757,666	2,250,506		2,250,506	(292,847)	1,957,659			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,155,234	653,542	2,195,021	7,003,797		7,003,797	(234,251)	6,769,546			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 Number McKinley Court #0051821 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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			60,153	60,153		60,153	3,678	63,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,949	65,949		65,949	(8,599)	57,350			32
33	Real Estate Taxes			84,301	84,301		84,301		84,301			33
34	Rent-Facility & Grounds			1,436,921	1,436,921		1,436,921	(115,911)	1,321,010			34
35	Rent-Equipment & Vehicles			104,495	104,495		104,495	3,242	107,737			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,751,819	1,751,819		1,751,819	(117,590)	1,634,229			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			27,196	27,196		27,196		27,196			38
39	Ancillary Service Centers		273,968	1,670,726	1,944,694		1,944,694		1,944,694			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			305,307	305,307		305,307		305,307			42
43	Other (specify):* Non-Allowable Cos	42,239		388,853	431,092		431,092	(431,092)				43
44	**TOTAL Special Cost Centers**	42,239	273,968	2,392,082	2,708,289		2,708,289	(431,092)	2,277,197			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,197,473	927,510	6,338,922	11,463,905		11,463,905	(782,933)	10,680,972			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 # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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 Refer-ence	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	(33,763)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(8,599)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,307)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,908)	43		18
19	Entertainment				19
20	Contributions	(5,249)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(178,031)	43		24
25	Fund Raising, Advertising and Promotional	(13,643)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,146)	43		28
29	Other-Attach Schedule See Page 5A	(195,912)	Var.		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (449,558)		$	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)	(333,375)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (333,375)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (782,933)		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		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

McKinley Court

ID# 0051821

Report Period Beginning: 01/01/2014

Ending: 12/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Nonallowable marketing events	$ (81,279)	43	1
2	Laboratory Costs	(21,148)	43	2
3	X-Ray Costs	(11,847)	43	3
4	Marketing Salary	(42,239)	43	4
5	Theft and Damages Loss	(1,950)	43	5
6	Lobbying Expense	(4,960)	20	6
7	IV Therapy Medicare	(11,175)	43	7
8	Other Services	(1,280)	43	8
9	Legal Expense	(4,907)	19	9
10	EKG - Medicare	(3,737)	43	10
11	Inhalation Therapy	(11,390)	43	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(195,912)		49

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 6 Supplemental		

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 [X] 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			$			$	$	1
2	V								2
3	V	N/A							3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ * 0	14

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

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	5	Utilities	$	Symphony Financial Services, LLC	100.00%	$ 581	$ 581	15
16	V	6	Maintenance		Symphony Financial Services, LLC	100.00%	5,352	5,352	16
17	V	10	Nursing & Medical Records		Symphony Financial Services, LLC	100.00%	43,894	43,894	17
18	V	15	Other		Symphony Financial Services, LLC	100.00%	8,769	8,769	18
19	V	17	Administrative	534,092	Symphony Financial Services, LLC	100.00%		(534,092)	19
20	V	19	Professional Services-Other		Symphony Financial Services, LLC	100.00%	22,466	22,466	20
21	V	20	Dues, Fees, Subscripts & Promos		Symphony Financial Services, LLC	100.00%	2,872	2,872	21
22	V	21	Clerical & General Office Exp-Salaries		Symphony Financial Services, LLC	100.00%	179,989	179,989	22
23	V	24	Travel & Seminar		Symphony Financial Services, LLC	100.00%	12,983	12,983	23
24	V	26	Insurance-Prop, Liab & Malpractice		Symphony Financial Services, LLC	100.00%	7,252	7,252	24
25	V	27	Other		Symphony Financial Services, LLC	100.00%	25,550	25,550	25
26	V	30	Depreciation		Symphony Financial Services, LLC	100.00%	3,678	3,678	26
27	V	34	Rent-Facility & Grounds		Symphony Financial Services, LLC	100.00%	(115,911)	(115,911)	27
28	V	35	Rent-Equipment & Vehicles		Symphony Financial Services, LLC	100.00%	3,242	3,242	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			$ 534,092			$ 200,717	$ * (333,375)	39

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

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Debra Hartman	24.50	Symphony Aspen Ridge, LLC D/B/A Symphony	Decatur	Symphony Healthcare	Lincolnwood	Sub Lessor	1
2	Hartman Family Fdn	4.50	Symphony Countryside, LLC D/B/A Countrysid	Aurora	Symphony M.L., LLC	Lincolnwood	Main Lessor	2
3	Hartman Dynasty Trust	4.50	Symphony Crestwood, LLC D/B/A Symphony o	Crestwood	Symphony HMG, LLC	Lincolnwood	Sub Lessor	3
4	Mark Hartman	4.50	Symphony Deerbrook, LLC D/B/A Symphony o	Joliet	Symphony Financial S	Lincolnwood	Mgmt Co.	4
5	Julie Thomas	4.50	Symphony Maple Crest, LLC D/B/A Maple Cre	Belvidere				5
6	Rena Dickman	4.50	Symphony Maple Ridge, LLC D/B/A Symphony	Lincoln				6
7	Robert Hartman	4.00	Symphony McKinley, LLC D/B/A McKinley Co	Decatur				7
8	Jack Hartman	3.00	Symphony Northwoods, LLC D/B/A Northwood	Belvidere				8
9	Joseph Hartman	3.00						9
10	David J. Hartman	20.00						10
11	Jay Flatt	3.00	Bronzeville Park	Chicago	NuCare Services	Lincolnwood	Bookeeping Mgmt	11
12	Gerry Jenich	10.00	California Gardens Corp.	Chicago	7257 N. Lincoln Ave, L	Lincolnwood	Building Rental	12
13	IBEX Mgmt Svces, LLC	10.00	Claremont Rehab. & Living	Buffalo Grove	Diamond Insurance	Northbrook	Work Comp Ins.	13
14			Claremont - Hanover Park	Hanover Park	Mapleleaf Insurance	Grand Cayman	Liability/Work Com	14
15			Claridge Imperial, LTD.	Chicago	Seasons Hospice	Park Ridge	Hospice *	15
16			Jackson Corp	Chicago	JLR Financial Svcs. C	Lincolnwood	Management Co.	16
17			Monroe Pavillion	Chicago	KFT Services, LLC	Lincolnwood	Management Co. **	17
18			Renaissance at 87th Street	Chicago	Drake Louis Enterpris	Lincolnwood	Management Co. **	18
19			Renaissance at Midway	Chicago	Integra Healthcare Eq	Elmhurst	DME & Med. Suppl	19
20			Renaissance at South Shore	Chicago	Lifeline Ambulance, L	Chicago	Ambulance	20
21			Renaissance at Park South	Chicago	Integra Respiratory Se	Elmhurst	Respiratory Service	21
22			Aria Post Acute Care	Hillside				22
23			Seven Oaks	Glendale, Wiscosin				23
24			Renaissance East	Mesa, Arizona	* No expense paid by home to the related			24
25			Renaissance West	Mesa, Arizona	entity, therefore no page 6 or 8.			25
26			Renaissance Village IL	Mesa, Arizona	** No expense of this related business			26
27			Renaissance Village AL	Mesa, Arizona	allocated to homes			27
28								28
29								29
30								30

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	No owners receive compensation from this facility.								$		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 # 0051821 Report Period Beginning: 01/01/2014 Ending: 2/31/2014

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: Symphony Financial Services, LLC
Street Address: 7257 N. Lincoln Ave
City / State / Zip Code: Lincolnwood, IL 60712
Phone Number: (847) 933-2600
Fax Number: ( )

	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	5	Utilities	Occupied Bed Days	418,769	8	$ 5,138	$	47,371	$ 581	1
2	6	Maintenance	Occupied Bed Days	418,769	8	47,313		47,371	5,352	2
3	10	Nursing & Med. Records Salary	Occupied Bed Days	418,769	8	388,030	388,030	47,371	43,894	3
4	15	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	77,521		47,371	8,769	4
5	19	Professional Service Legal	Occupied Bed Days	418,769	8	14,326		47,371	1,621	5
6	19	Professional Service Other	Occupied Bed Days	418,769	8	184,271		47,371	20,845	6
7	20	Dues, Fees, Subscripts & Promoti	Occupied Bed Days	418,769	8	25,386		47,371	2,872	7
8	21	Clerical & Gen ofc exp -Salary	Occupied Bed Days	418,769	8	1,490,276	1,490,276	47,371	168,580	8
9	21	Clerical & Gen ofc expenses	Occupied Bed Days	418,769	8	100,854		47,371	11,409	9
10	24	Travel & Seminar	Occupied Bed Days	418,769	8	114,768		47,371	12,983	10
11	26	Ins-Prop, Liab & Malpractice	Occupied Bed Days	418,769	8	64,109		47,371	7,252	11
12	27	Other-Mgmt Alloc of Benefits	Occupied Bed Days	418,769	8	225,869		47,371	25,550	12
13	30	Depreciation	Occupied Bed Days	418,769	8	32,512		47,371	3,678	13
14	34	Rent - Facility & Grounds	Occupied Bed Days	418,769	8	(1,024,677)		47,371	(115,911)	14
15	35	Rent - Equipment	Occupied Bed Days	418,769	8	17,271		47,371	1,954	15
16	35	Rent - Vehicles	Occupied Bed Days	418,769	8	11,389		47,371	1,288	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,774,356	$ 1,878,306		$ 200,717	25

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	The Private Bank		X	Line of Credit	Interest Only	12/30/2011	17,520,000	2,227,659	12/30/15	0.0550	65,949	6
7												7
8												8
9	TOTAL Facility Related						$ 17,520,000	$ 2,227,659			$ 65,949	9
	B. Non-Facility Related*											
10												10
11												11
12								Interest Income Offset			(8,599)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (8,599)	14
15	TOTALS (line 9+line14)						$ 17,520,000	$ 2,227,659			$ 57,350	15

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

*** 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 # 0051821 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**		$ 92,500	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.)	2013	$ 86,201	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,299)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 90,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 84,301	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	88,923	8
	2010	88,200	9
	2011	87,935	10
	2012	88,070	11
	2013	86,201	12

2014 Tax Accural = $86,201 x 1.05 = 90,511; Use $90,600

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME McKinley Court COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0051821

CONTACT PERSON REGARDING THIS REPORT Elizabeth Koshy

TELEPHONE (847) 745-6205 FAX #: (847) 673-2284

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

Enter the tax index number and real estate tax assessed for 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-03-251-015	Nursing Home	$ 86,201.37	$ 86,201.37
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 86,201.37	$ 86,201.37

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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 # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. [X] (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).

N/A

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: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	N/A			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Wiring Data Cables			2013	6,612	331	20	331		491	9
10	Remodeling - Custom Built Cabinetry & Millwork			2013	61,400	3,070	20	3,070		3,256	10
11	-Lobby, reception area and activity room										11
12											12
13	Remodeling - Drywall/Demo/Carpentry - Lobby/Activity Room			2013	3,000	150	20	150		159	13
14											14
15	Remodeling - Painting/Wallcovering			2013	34,545	3,455	10	3,455		3,743	15
16	-Lobby, reception area and activity room										16
17											17
18	Remodeling - Electrical and plumbing			2013	4,271	213	20	213		226	18
19	-Lobby, reception area and activity room										19
20											20
21	Remodeling - Flooring			2013	30,397	1,520	20	1,520		1,612	21
22	-Lobby, Vestibule, reception area and activity room										22
23											23
24	Remodeling - General Contract & Architecture			2013	20,960	1,049	20	1,049		1,112	24
25	-Lobby, Vestibule, Courtyard, reception area and activity room										25
26											26
27											27
28	Facility Remodeling			2014	419,056	14,147	5-20	14,147		14,147	28
29	-General contractors fees (Throughout Facility)										29
30	-Custom millwork: Reception Area, Activity Room,										30
31	Coffee Station & Nurses' Station										31
32	-Electrical: Install New Gable Light on Front of Entrance										32
33	-Floor covering: Activity Room										33
34	-Ceramic tile: Activity Room										34
35											35
36											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 # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	Continued from Page 12		$	$		$	$	$	37
38	-Demo/carpentry/drywall (Throughout Facility)								38
39	-Interior painting/wall paper: Hallway								39
40	-Relocated Electrical for New Nurses' Stations (North & South)								40
41	-Plumbing: Shower Room								41
42	-Floor coverings (Plank/Base): Cooridors & All Resident Rooms								42
43	-Wall coverings: Hallways								43
44	-Gazebo (Exterior)								44
45	-Interior painting (5 Offices, Dining Room & 5 Resident Rooms)								45
46	-Electrical: Lighting Upgrade for Court Yard; Removed Sconces								46
47	-Floor coverings (Plank/Base): Cooridors & All Resident Rooms								47
48	-Landscaping								48
49	-Asphalt Patching: Parking Lot								49
50	-Interior painting: Barber Shop, Dining Room & 3 Resident Rooms								50
51	-Electrical: Sconces in Main Hall; Lights in Shower Rooms								51
52	-Window treatments: Dining Room, Therapy Room, Bistro								52
53	Doctor's Office, Admin. Office, Resident Rooms: 312, 313								53
54	314, 316, 318, 305, 306, 307, 308, 315, 301, 302, 303, 304, 309								54
55	310, 311 & 320								55
56	-Doors: Saddle Threshold & Clear Temp. Glass - Exterior								56
57	-Telephone system/Data Module (Throughout Facility)								57
58	-Plumbing: Hot Water on North & South; Valve in Kitchen								58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 580,241	$ 23,935		$ 23,935	$	$ 24,746	70

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

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	$ 167,319	$ 29,819	$ 29,819	$	5-7	$ 46,558	71
72	Current Year Purchases	70,649	5,809	5,809		5-7	5,809	72
73	Fully Depreciated Assets							73
74	Allocated from Mgmt. Co.	20,120		3,678	3,678	5-7	5,521	74
75	TOTALS	$ 258,088	$ 35,628	$ 39,306	$ 3,678		$ 57,888	75

D. Vehicle Costs. (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	Facility use	2009 Ford	2014	$ 9,904	$ 590	$ 590	$	7	$ 590	76
77										77
78										78
79										79
80	TOTALS			$ 9,904	$ 590	$ 590	$		$ 590	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)	$ 848,233	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 60,153	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,831	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,678	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 83,224	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	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

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

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

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Diana Master Landlord, LLC

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. [X] 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:	1986	150	12/31/2011	$ 1,433,815	10	10	3
4	Additions							4
5								5
6	Allocated from Mgmt. Co.				(115,911)			6
7	TOTAL		150		$ 1,317,904 **			7

8. List separately any amortization of lease expense included on page 4, line 34. 3,106
This amount was calculated by dividing the total amount to be amortized 31,062
by the length of the lease 10 .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning 12/31/2011
Ending 12/31/2021

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2015	$ 1,020,000
13.	/2016	$ 1,040,400
14.	/2017	$ 1,061,208

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: $ 100,292 Description: See Schedule 14A
(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 Bus	$ 1,228	$ 7,445	17
18					18
19					19
20					20
21	TOTAL		$ 1,228	$ 7,445	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: **McKinley Court**
IDPH License ID Number: **0051821**
Fiscal Year End: **12/31/2014**

Schedule 14A

XIV. Rental Costs
Line 16 Rental Amount for Moveable Equipment

Rental Description	Amount
General DME	14,489
Bed Frame/Mattresses	14,807
Wheelchairs	114
VAC Freedom	14,206
Helium, Hazmat	374
Domestic Container	1,905
Plant Rental	4,980
Cooler	398
Water	528
Chairs and Tables	530
Copier	22,921
Mailing Machine	1,134
Computer	959
Digital Music	1,183
Oxygen	12,720
Equipment Fee	5,148
Signature Events Rental	653
Home Office Allocation	3,242
Total - Line 16	**100,292**

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

It is the policy of this facility to only hire certified nurses aides.

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

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.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39(3)	hrs	$	10,419	$ 750,188	$	10,419	$ 750,188	1
2	Licensed Speech and Language Development Therapist	39(3)	hrs		2,034	146,457		2,034	146,457	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39(3)	hrs		10,427	750,753		10,427	750,753	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				262,191		262,191	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Schedule 16A	39(3)				23,328			23,328	12
13	Other (specify): Oxygen						11,777		11,777	13
14	TOTAL			$	22,880	$ 1,670,726	$ 273,968	22,880	$ 1,944,694	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: **McKinley Court**
IDPH License ID Number: **0051821**
Fiscal Year End: **12/31/2014**

Schedule 16A

XIV. Special Services (Direct Cost)
Line 12 Other (specify)

Description	Units	Amount
INHALATION THERAPY-PRIVATE		3,965
INHALATION THERAPY-MEDICAID		19,289
OTHER SERVICES - PRIVATE		74
Total - Line 12	**-**	**23,328**

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2014 (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	$ 102,779	$ 102,779	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 289,440)	4,213,694	4,213,694	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,781	2,781	6
7	Other Prepaid Expenses	182,940	182,940	7
8	Accounts Receivable (owners or related parties)	316,696	316,696	8
9	Other(specify): Patient Personal Funds	10,794	10,794	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,829,684	$ 4,829,684	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	543,877	580,241	15
16	Equipment, at Historical Cost	284,234	267,992	16
17	Accumulated Depreciation (book methods)	(77,901)	(83,224)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Lease Cost	21,744	21,744	22
23	Other(specify): Deposits	302,213	302,213	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,074,167	$ 1,088,966	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,903,851	$ 5,918,650	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,182,701	$ 1,182,701	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	229,176	229,176	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	90,600	90,600	32
33	Accrued Interest Payable	429	429	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	1,026,362	1,026,362	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,529,268	$ 2,529,268	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	2,227,659	2,227,659	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,227,659	$ 2,227,659	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,756,927	$ 4,756,927	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,146,924	$ 1,161,723	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,903,851	$ 5,918,650	48

***(See instructions.)**

Facility Name: **McKinley Court**
IDPH License ID Number: **0051821**
Fiscal Year End: **12/31/2014**

Schedule 17A

XV. Balance Sheet
Line 36 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Exchange Formation Leashold	(132,083)	(132,083)
Security Deposit Payable	(49,619)	(49,619)
Operating Expenses	(95,552)	(95,552)
Management Fees - Symphony	(251,212)	(251,212)
Ins Wrkrs Comp.Deduct./ Settle	(117,005)	(117,005)
Accumulated Amortization Def	7,155	7,155
State Unemployment Tax	(8,023)	(8,023)
Federal Unemployment Tax	(780)	(780)
Sales Tax	(332)	(332)
Payroll Taxes Other	(25,884)	(25,884)
Accrued Employee Benefits	(139,140)	(139,140)
FICA & W/H Fed	(70)	(70)
Due to IDPA - Bed Tax	(37,185)	(37,185)
Due to/from the Kensington	(58,754)	(58,754)
Exchange	(40,699)	(40,699)
Due to Nucare	(18,964)	(18,964)
Due to Symphony	(43,612)	(43,612)
Wage Assign & Garnishments	(2,947)	(2,947)
Patient Personal Funds	(11,656)	(11,656)
Total - Line 36	**(1,026,362)**	**(1,026,362)**

Facility Name & ID Number McKinley Court **#** 0051821 **Report Period Beginning:** 01/01/2014 **Ending:** 12/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 732,201	1	
2	Restatements (describe):		2	
3	**Prior Year Adjustment**	549	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 732,750	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	414,174	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)**	$ 414,174	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)**	$ 1,146,924	24	*

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

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,138,216	1
2	Discounts and Allowances for all Levels	(2,988,521)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,149,695	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,260,449	6
7	Oxygen	632	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,261,081	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	338,334	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	96,073	19
20	Radiology and X-Ray	4,793	20
21	Other Medical Services	19,504	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 458,704	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,599	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8,599	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,878,079	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,509,505	31
32	Health Care	3,243,786	32
33	General Administration	2,250,506	33
	B. Capital Expense		
34	Ownership	1,751,819	34
	C. Ancillary Expense		
35	Special Cost Centers	2,402,982	35
36	Provider Participation Fee	305,307	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,463,905	40
41	**Income before Income Taxes (line 30 minus line 40)****	414,174	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 414,174	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,255,206	44
45	Private Pay - Net Inpatient Revenue	1,496,171	45
46	Medicare - Net Inpatient Revenue	2,164,486	46
47	Other-(specify) Hospice	129,863	47
48	Other-(specify) Managed Care	103,969	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,149,695	49

* **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.**

*** **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.**

^ **Tax Return prepared on a cash basis.**

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,950	2,113	$ 93,202	$ 44.11	1
2	Assistant Director of Nursing	2,234	2,403	74,586	31.04	2
3	Registered Nurses	13,695	14,504	365,798	25.22	3
4	Licensed Practical Nurses	36,676	40,069	1,019,332	25.44	4
5	CNAs & Orderlies	88,510	95,062	1,178,304	12.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,893	3,186	54,991	17.26	8
9	Activity Director	4,703	5,497	89,627	16.30	9
10	Activity Assistants					10
11	Social Service Workers	3,044	3,397	62,143	18.29	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	28,878	31,154	299,933	9.63	15
16	Dishwashers					16
17	Maintenance Workers	2,390	2,824	63,128	22.35	17
18	Housekeepers	20,546	22,929	268,145	11.69	18
19	Laundry	9,002	10,252	95,201	9.29	19
20	Administrator	1,927	2,242	106,739	47.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,829	18,101	350,463	19.36	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	2,266	2,516	33,642	13.37	31
32	Other Health Ca					32
33	Other(specify) Marketing	1,631	1,877	42,239	22.50	33
34	TOTAL (lines 1 - 33)	237,174	258,126	$ 4,197,473 *	$ 16.26	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 11,019	1(3)	35
36	Medical Director	Monthly	65,640	9(3)	36
37	Medical Records Consultant	Monthly	1,760	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,274	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	2,265	11(3)	44
45	Social Service Consultant				45
46	Other(specify) Wound Care	Monthly	12,000	10(3)	46
47	Program Consultant	Monthly	900	11(3)	47
48	Orthopedic Consultant	Monthly	24,000	10(3)	48
49	TOTAL (lines 35 - 48)		$ 126,858		49

C. CONTRACT NURSES

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

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberly Jordan	Administrator	0	$ 106,739
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 106,739

B. Administrative - Other

Description	Amount
Management Fees (Eliminated in Col. 7)	$ 534,092
TOTAL (agree to Schedule V, line 17, col. 3)	$ 534,092
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See Schedule 21A		$ 241,963
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 241,963

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 4,970
Unemployment Compensation Insurance	77,858
FICA Taxes	306,960
Employee Health Insurance	103,444
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement	21,494
Employee Benefits - Other	26,277
Employees' Physical Exams	2,598
TOTAL (agree to Schedule V, line 22, col.8)	$ 543,601

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

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	825
Health Care Worker Background Check	
(Indicate # of checks performed 110)	1,315
Patient Background Checks	
Miscellaneous Licenses & Fees	450
Illinois Council on Long Term Care	15,030
Miscellaneous Dues & Subscriptions	18,730
Lobbying Expense Offset	(4,960)
Allocated from Mgmt. Co.	2,872
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(9,146)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,096

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,489
Allocated from Mgmt. Co.	12,983
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 20,472

* Attach copy of IMRF notifications

**See instructions.

Facility Name: **McKinley Court**
IDPH License ID Number: **0051821**
Fiscal Year End: **12/31/2014**

Schedule 21A

XIX. SUPPORT SCHEDULES

C. Professional Services

Vendor	Type	Amount
Hipp Law office	Legal Fees	4,907
Much Shelist	Legal Fees	1,151
Stone McGuire & Siegel	Legal Fees	15,212
ABILITY NETWORK	DATA PROCESSING	1,938
Adobe	Web Hosting	28
Aon E Solutions Inc	Riskmgmt Sftwr/Maint	1,716
COMCAST	INTERNET	26,106
Creative Technology	Email Protection	10,876
EHEALTH DATA SOLUTIONS	CARE WATCH SERVICE	5,112
EVAULT	PROTECTONE- 36MO-SERVERON	1,728
HDSI	FILE RETRIEVAL	4,343
HK Payroll Services	Work Tax Credit	866
IIT/SOURCETECH	OPERATOR SUPPORT	1,380
Jeremy Pierson	SEO Improvements	85
Point B Communication	Yrly Web Hosting	1,611
Provinet Solutions	Outsourced IT Services	1,091
Telemedicine Solutions	Wound Rounds Care	12,507
The Data Bank	Jacho Credentials	302
The Joint Commission	Subacute Care	2,500
WESCOME SOLUTIONS	DATA PROCESSING/BILLING	22,516
ZIR-MED	ELIGIBILITY SYSTEM MANAGEM	404
ACHIEVE ACCREDITATION	HAZARDOUS MATERIALS PLAN	19,970
PERSONNEL PLANNERS	HR DIRECTOR SEACH	2,138
PINNACLE QUALITY INSIGHT	CUSTOMER SATISFACTION PROG	2,160
SYMPHONY FINANCIAL SRVCS	FORMATION HEALTHCARE	73,929
Administrative Consultants	Consulting	900

McGladrey LLP	Accounting Fees	26,487
	Total (agree to Schedule V, line 19, column 3)	241,963

Allocated from Management Company Legal Fees	1,621
Allocated from Management Company Professional Services	20,845
Less: Non-Allowable Legal Fees	(4,907)
Total (agree to Schedule V, line 19, column 8)	259,522

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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

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

Facility Name & ID Number McKinley Court # 0051821 Report Period Beginning: 01/01/2014 Ending: 12/31/2014

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. **IL Council LTC - $10,070**

(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? **N/A**

(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. $ **21,392** 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. **N/A**

(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. $ **305,307**
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? **No** Indicate the amount. $ **0**

(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. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **5**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
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? **Yes**
Firm Name: **McGladrey LLP**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.