



Facility Name & ID Number Casey Care Center

# 0039800 Report Period Beginning: 7/1/99 Ending: 6/30/00

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	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	106	Intermediate (ICF)	106	38,796	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,796	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	19,962	5,546		25,508	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,962	5,546		25,508	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.75%

D. How many bed-hold days during this year were paid by Public Aid? 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  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

I. On what date did you start providing long term care at this location?  
 Date started 10/01/94

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date 10/01/94 NO

K. Was the facility certified for Medicare during the reporting year?  
 YES  NO  If YES, enter number of beds certified N/A and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS  
 ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 6/30/00 Fiscal Year: 6/30/00  
 \* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 7/1/99 Ending: 6/30/00

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	100,247	6,793	4,545	111,585		111,585		111,585		1
2	Food Purchase		93,395		93,395		93,395	(14,702)	78,693		2
3	Housekeeping	78,091	15,595		93,686		93,686		93,686		3
4	Laundry	26,302	12,055		38,357		38,357		38,357		4
5	Heat and Other Utilities			51,250	51,250		51,250	285	51,535		5
6	Maintenance	30,929		34,878	65,807		65,807	4,814	70,621		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	235,569	127,838	90,673	454,080		454,080	(9,603)	444,477		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	731,002	30,736	535	762,273		762,273		762,273		10
10a	Therapy			544	544		544		544		10a
11	Activities	20,083	4,755	339	25,177		25,177	2,936	28,113		11
12	Social Services	19,602		1,952	21,554		21,554		21,554		12
13	Nurse Aide Training										13
14	Program Transportation			1,231	1,231		1,231		1,231		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	770,687	35,491	10,601	816,779		816,779	2,936	819,715		16
	<b>C. General Administration</b>										
17	Administrative	82,104		52,367	134,471		134,471	(52,367)	82,104		17
18	Directors Fees			(22)	(22)		(22)	14,399	14,377		18
19	Professional Services			51,565	51,565		51,565	56,903	108,468		19
20	Dues, Fees, Subscriptions & Promotions			6,125	6,125		6,125	2,372	8,497		20
21	Clerical & General Office Expenses	152,239	8,500	20,181	180,920		180,920	36,332	217,252		21
22	Employee Benefits & Payroll Taxes			121,717	121,717		121,717	109,312	231,029		22
23	Inservice Training & Education			412	412		412	5,312	5,724		23
24	Travel and Seminar			9,521	9,521		9,521	10,966	20,487		24
25	Other Admin. Staff Transportation			1,029	1,029		1,029	761	1,790		25
26	Insurance-Prop.Liab.Malpractice			200	200		200	36,930	37,130		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	234,343	8,500	263,095	505,938		505,938	220,920	726,858		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,240,599	171,829	364,369	1,776,797		1,776,797	214,253	1,991,050		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

\*\* See schedule of adjustments attached at end of cost report.

Facility Name &amp; ID Number

Casey Care Center

#0039800

Report Period Beginning:

7/1/99

Ending:

6/30/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			6,906	6,906		6,906	127,893	134,799			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,696	8,696		8,696	291,228	299,924			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			351,830	351,830		351,830	(342,650)	9,180			34
35	Rent-Equipment & Vehicles			7,416	7,416		7,416	9,976	17,392			35
36	Other (specify):* Insurance-MIP							16,405	16,405			36
37	<b>TOTAL Ownership</b>			374,848	374,848		374,848	102,852	477,700			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							1,906	1,906			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,194	58,194		58,194		58,194			42
43	Other (specify):* Nonallowable costs			4,869	4,869		4,869	(4,869)				43
44	<b>TOTAL Special Cost Centers</b>			63,063	63,063		63,063	(2,963)	60,100			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,240,599	171,829	802,280	2,214,708		2,214,708	314,142	2,528,850			45

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

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

# 0039800

Report Period Beginning: 7/1/99

Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF 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	(565)	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	6,784	30		9
10	Interest and Other Investment Income	(10,455)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(7,012)	32		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	(900)	43		18
19	Entertainment				19
20	Contributions	(45)	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	(323)	43		24
25	Fund Raising, Advertising and Promotional	(1,445)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,366)	43		28
29	Other-Attach Schedule See Attached Schedule 5A	6,415			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (8,912)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	323,054		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$ 323,054</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ 314,142</b>		<b>37</b>

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center  
Provider #0039800  
June 30, 2000

Schedule 5A

Schedule VI - Adjustment Detail  
Line 29 - Other

	Amount	Sch V Reference
Political Contributions	(225)	43
Offset Miscellaneous Income	(3,679)	21
Interest Income	10,273	n/a
Miscellaneous Income	46	n/a
	<u>6,415</u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center

ID# 0039800

Report Period Beginning: 7/1/99

Ending: 6/30/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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			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			49
50			50
51			51
52			52
53			53
54			54
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56			56
57			57
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61			61
62			62
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64			64
65			65
66			66
67			67
68			68
69			69
70			70
71			71
72			72
73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	0	90

Facility Name &amp; ID Number Casey Care Center

# 0039800

Report Period Beginning: 7/1/99

Ending: 6/30/00

## 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
Caravilla Resident Centers, Inc. - See attached Schedule 7A	100.00%	See attached Related Party Schedule		See attached Related Party Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	6 Repairs & maintenance	\$	Center for Residential Management, Inc.	**	\$ 1,218	\$	1,218	1
2	V	10 Medical supplies		Center for Residential Management, Inc.	**				2
3	V	11 Activity programming		Center for Residential Management, Inc.	**	2,466		2,466	3
4	V	17 Management fees	52,367	Center for Residential Management, Inc.	**	52,463		96	4
5	V	18 Board fees		Center for Residential Management, Inc.	**	4,995		4,995	5
6	V	19 Professional fees		Center for Residential Management, Inc.	**	8,898		8,898	6
7	V	20 Licenses, dues & subscriptions		Center for Residential Management, Inc.	**	926		926	7
8	V	21 Office supplies & telephone		Center for Residential Management, Inc.	**	8,204		8,204	8
9	V	22 Employee benefits & payroll taxes		Center for Residential Management, Inc.	**	12,315		12,315	9
10	V	23 Inservice travel & education		Center for Residential Management, Inc.	**	21		21	10
11	V	24 Travel & seminar		Center for Residential Management, Inc.	**	3,612		3,612	11
12	V	25 Vehicle expense		Center for Residential Management, Inc.	**	602		602	12
13	V	26 Vehicle, fire & liability insurance		Center for Residential Management, Inc.	**	380		380	13
14	Total		\$ 52,367			\$ 96,100	\$ *	43,733	14

\*\* Center for Residential Management, Inc. is

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

SEE ACCOUNTANTS' COMPILATION REPORT Caravilla Resident Centers, Inc.'s parent company.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 Depreciation	\$	Center for Residential Management, Inc.	**	\$ 2,088	\$ 2,088
16	V	32 Interest expense		Center for Residential Management, Inc.	**	1,365	1,365
17	V	39 Ancillary service centers		Center for Residential Management, Inc.	**	1,906	1,906
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 5,359	\$ * 5,359

\*\* Center for Residential Management, Inc. is

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

SEE ACCOUNTANTS' COMPILATION REPORT Caravilla Resident Centers, Inc.'s parent company.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management fees	\$	Caravilla Resident Centers, Inc.	100.00%	\$ 12,750	\$ 12,750
16	V	18 Board fees		Caravilla Resident Centers, Inc.	100.00%	9,404	9,404
17	V	19 Professional fees		Caravilla Resident Centers, Inc.	100.00%	6,218	6,218
18	V	20 Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	402	402
19	V	21 Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	1,112	1,112
20	V	22 Employee benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	66,753	66,753
21	V	24 Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	150	150
22	V	26 Vehicle, fire & liability insurance		Caravilla Resident Centers, Inc.	100.00%	9,879	9,879
23	V	32 Interest expense		Caravilla Resident Centers, Inc.	100.00%	3,833	3,833
24	V	36 Insurance - MIP		Caravilla Resident Centers, Inc.	100.00%	16,405	16,405
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 126,906	\$ * 126,906

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 Utilities	\$	Developmental Services of Illinois, Inc.	**	\$ 285	\$ 285
16	V	6 Repairs & maintenance		Developmental Services of Illinois, Inc.	**	3,596	3,596
17	V	11 Activity programming		Developmental Services of Illinois, Inc.	**	470	470
18	V	17 Management fees	65,213	Developmental Services of Illinois, Inc.	**		(65,213)
19	V	19 Professional fees		Developmental Services of Illinois, Inc.	**	34,642	34,642
20	V	20 Licenses, dues & subscriptions		Developmental Services of Illinois, Inc.	**	1,037	1,037
21	V	21 Office supplies & telephone		Developmental Services of Illinois, Inc.	**	30,479	30,479
22	V	22 Employee benefits & payroll taxes		Developmental Services of Illinois, Inc.	**	15,542	15,542
23	V	23 Inservice travel & education		Developmental Services of Illinois, Inc.	**	5,291	5,291
24	V	24 Travel & seminar		Developmental Services of Illinois, Inc.	**	7,204	7,204
25	V	25 Vehicle expense		Developmental Services of Illinois, Inc.	**	159	159
26	V	26 Vehicle, fire & liability insurance		Developmental Services of Illinois, Inc.	**	2,446	2,446
27	V	30 Depreciation		Developmental Services of Illinois, Inc.	**	2,819	2,819
28	V	32 Interest expense		Developmental Services of Illinois, Inc.	**	16,634	16,634
29	V	34 Rent		Developmental Services of Illinois, Inc.	**	9,180	9,180
30	V	35 Vehicle lease & equipment rental		Developmental Services of Illinois, Inc.	**	9,976	9,976
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 65,213			\$ 139,760	\$ * 74,547

\*\* Developmental Services of Illinois, Inc. is Caravilla

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

SEE ACCOUNTANTS' COMPILATION REPORT Resident Centers, Inc.'s management company.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Professional fees	\$	Caravilla Charitable Corporation	**	\$ 7,145	\$ 7,145
16	V	20 Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	7	7
17	V	21 Office supplies & telephone		Caravilla Charitable Corporation	**	216	216
18	V	26 Vehicle, fire & liability insurance		Caravilla Charitable Corporation	**	24,225	24,225
19	V	30 Depreciation		Caravilla Charitable Corporation	**	116,202	116,202
20	V	32 Interest expense		Caravilla Charitable Corporation	**	286,863	286,863
21	V	34 Rent expense	351,830	Caravilla Charitable Corporation	**		(351,830)
22	V	n/a Interest income		Caravilla Charitable Corporation	**	(10,273)	(10,273)
23	V	n/a Miscellaneous income		Caravilla Charitable Corporation	**	(46)	(46)
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 351,830			\$ 424,339	\$ * 72,509

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

\*\* Caravilla Charitable Corporation and Caravilla SEE ACCOUNTANTS' COMPILATION REPORT Resident Centers, Inc. have the same parent company.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	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		\$			\$	0 \$ *	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	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		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	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		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	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		\$			\$	0 \$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	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		\$			\$	0 \$ *	39

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

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 7/1/99 Ending: 6/30/00

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Bauer	President	Board Member	None	9,444	2 hrs/mtg.		Board fees	\$ 2,556	L18, C8	1
2	Darrell Boehne	Director	Board Member	None	11,887	2 hrs/mtg.		Board fees	1,113	L18, C8	2
3	Duane Satterwhite	Director	Board Member	None	1,756	2 hrs/mtg.		Board fees	1,444	L18, C8	3
4	Roger Ryan	Vice President	Board Member	None	1,756	2 hrs/mtg.		Board fees	1,444	L18, C8	4
5	Ronald O'Daniell	Director	Board Member	None	1,757	2 hrs/mtg.		Board fees	1,443	L18, C8	5
6	William Armstrong	Treasurer	Board Member	None	1,757	2 hrs/mtg.		Board fees	1,443	L18, C8	6
7	Kay Baker	Secretary	Board Member	None	1,757	2 hrs/mtg.		Board fees	1,443	L18, C8	7
8	Ron Schroeder	Director	Board Member	None	13,048	2 hrs/mtg.		Board fees	752	L18, C8	8
9	Edward Childers	Director	Board Member	None	13,060	2 hrs/mtg.		Board fees	940	L18, C8	9
10	Eugene Humphrey	Director	Board Member	None	7,248	2 hrs/mtg.		Board fees	752	L18, C8	10
11	Shawn Jeffers	Director	Board Member	None	2,899	2 hrs/mtg.		Board fees	301	L18, C8	11
12	Orland Bauer	Director	Board Member	None	8,054	2 hrs/mtg.		Board fees	746	L18, C8	12
13								TOTAL	\$ 14,377		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.

SEE ATTACHED SCHEDULE 7A

\*\* 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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

# 0039800 Report Period Beginning: 7/1/99

Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Center for Residential Management, Inc.  
 Street Address 4239 W. War Memorial Drive, Suite 302  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 685-0595  
 Fax Number (309) 685-8463

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					\$	\$		\$	1
2	6	Repairs & maintenance	Bed days available	206,424	20	6,488	38,796	1,218	2
3	17	Management fees	Bed days available	206,424	20	279,150	38,796	52,463	3
4	18	Board fees	Bed days available	206,424	20	26,600	38,796	4,995	4
5	19	Professional fees	Bed days available	206,424	20	47,365	38,796	8,898	5
6	20	Licenses, dues & subscriptions	Bed days available	206,424	20	401	38,796	72	6
7	21	Office supplies & telephone	Bed days available	206,424	20	14,574	38,796	2,733	7
8	22	Employee benefits & payroll taxes	Bed days available	206,424	20	27,615	38,796	5,196	8
9	24	Travel & seminar	Bed days available	206,424	20	7,941	38,796	1,497	9
10	25	Vehicle expense	Bed days available	206,424	20	3,189	38,796	602	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	2,009	38,796	380	11
12	30	Depreciation	Bed days available	206,424	20	11,103	38,796	2,088	12
13	32	Interest expense	Bed days available	206,424	20	7,240	38,796	1,365	13
14									14
15									15
16									16
17	11	Activity programming	Direct method					2,466	17
18	20	Licenses, dues & subscriptions	Direct method					854	18
19	21	Office supplies & telephone	Direct method					5,471	19
20	22	Employee benefits & payroll taxes	Direct method					7,119	20
21	23	Inservice travel & education	Direct method					21	21
22	24	Travel & seminar	Direct method					2,115	22
23	39	Ancillary service centers	Direct method					1,906	23
24									24
25	TOTALS				\$	433,675	\$	101,459	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

# 0039800 Report Period Beginning: 7/1/99

Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Caravilla Resident Centers, Inc.  
 Street Address 4239 W. War Memorial Drive, Suite 302  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 685-0595  
 Fax Number ( 309) 685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management fees	Number of beds	235	3	\$ 34,250	\$ 106	\$ 12,750	1
2	18	Board fees	Number of beds	235	3	20,800	106	9,404	2
3	19	Professional fees	Number of beds	235	3	13,817	106	6,218	3
4	20	Licenses, dues & subscriptions	Number of beds	235	3	892	106	402	4
5	21	Office supplies & telephone	Number of beds	235	3	2,468	106	1,112	5
6	24	Travel & seminar	Number of beds	235	3	380	106	150	6
7	32	Interest expense	Number of beds	235	3	8,499	106	3,833	7
8									8
9	22	Employee benefits & payroll taxes	Direct method					66,753	9
10	26	Vehicle, fire & liability insurance	Direct method					9,879	10
11	36	Insurance - MIP	Direct method					16,405	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					\$ 81,106	\$	\$ 126,906	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

# 0039800 Report Period Beginning: 7/1/99

Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Developmental Services of Illinois, Inc.  
 Street Address 4239 W. War Memorial Drive, Suite 302  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number (309) 685-0595  
 Fax Number (309) 685-8463

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	Utilities	Bed days available	206,424	20	\$ 1,518	\$ 38,796	\$ 285	1
2	6	Repairs & maintenance	Bed days available	206,424	20	19,133	38,796	3,596	2
3	11	Activity programming	Bed days available	206,424	20	2,500	38,796	470	3
4	19	Professional fees	Bed days available	206,424	20	184,323	38,796	34,642	4
5	20	Licenses, dues & subscriptions	Bed days available	206,424	20	5,518	38,796	1,037	5
6	21	Office supplies & telephone	Bed days available	206,424	20	162,176	38,796	30,479	6
7	22	Employee benefits & payroll taxes	Bed days available	206,424	20	82,697	38,796	15,542	7
8	23	Inservice travel & education	Bed days available	206,424	20	28,154	38,796	5,291	8
9	24	Travel & seminar	Bed days available	206,424	20	38,328	38,796	7,204	9
10	25	Vehicle expense	Bed days available	206,424	20	846	38,796	159	10
11	26	Vehicle, fire & liability insurance	Bed days available	206,424	20	13,012	38,796	2,446	11
12	30	Depreciation	Bed days available	206,424	20	15,000	38,796	2,819	12
13	32	Interest expense	Bed days available	206,424	20	88,507	38,796	16,634	13
14	34	Rent	Bed days available	206,424	20	48,842	38,796	9,180	14
15	35	Vehicle lease & equipment rental	Bed days available	206,424	20	53,081	38,796	9,976	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 743,635	\$	\$ 139,760	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

# 0039800 Report Period Beginning: 7/1/99

Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

# 0039800 Report Period Beginning: 7/1/99

Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									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				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center# 0039800

Report Period Beginning:

7/1/99

Ending:

6/30/00

## 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	
						Original	Balance					
	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									
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	NCS Healthcare, Inc.		X	Hardware/Software	\$728	10/31/98	\$ 29,136	\$ 18,345	9/30/03	0.1429	\$ 1,753	1
2	Continental Wingate		X	Purchase facility	\$55,560	9/19/96	7,402,500	3,271,877	10/01/31	0.0855	280,686	2
3	Lucent Technologies		X	Purchase phone system	\$175	5/30/97	6,997	3,406	05/31/02	0.1731	912	3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8							Amortization expense				9,029	8
9	TOTAL Facility Related				\$56,463.00		\$ 7,438,633	\$ 3,293,628			\$ 292,380	9
	<b>B. Non-Facility Related*</b>											
10							Finance charges				7,012	10
11							Offset of interest income				(10,455)	11
12							Non-allowable finance charges				(7,012)	12
13							Parent and management company allocation				17,999	13
14	TOTAL Non-Facility Related						\$	\$			\$ 7,544	14
15	TOTALS (line 9+line14)						\$ 7,438,633	\$ 3,293,628			\$ 299,924	15

\* 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.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center# 0039800 Report Period Beginning: 7/1/99 Ending: 6/30/00

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

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	\$		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.)	\$		2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	N/A	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$		7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1995	8	
	1996	9	
	1997	10	
	1998	11	
	1999	12	
	<b>FOR OFF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 1999 \$	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.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center# 0039800 Report Period Beginning:7/1/99 Ending:6/30/00**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 21,285 B. General Construction Type: Exterior Block & Brick Frame Brick Number of Stories OneC. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.

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

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

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

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

NoneF. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
If so, please complete the following:1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A3. 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Resident Care</u>	<u>120,000</u>	<u>1994</u>	<u>\$ 110,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>120,000</b>		<b>\$ 110,000</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Casey Care Center

# 0039800

Report Period Beginning:

7/1/99

Ending:

6/30/00

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	106	1994	1970	\$ 2,025,900	\$	40	\$ 50,648	\$ 50,648	\$ 291,225	4
5		1998	1998	6,585		40	165	165	412	5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	Building Improvements		1995	2,586		15	172	172	940	9
10	4 doors		1995	715		15	48	48	192	10
11	3 furnace, 2 a/c's, 3 coils		1995	14,366		15	958	958	3,832	11
12	Windows		1996	20,184		15	1,346	1,346	4,543	12
13	Fire & security alarms		1996	9,560		15	637	637	2,150	13
14	Architecture costs		1996	7,939		15	529	529	1,785	14
15	Asphalt & sidewalk		1996	7,408		15	500	500	1,649	15
16	Roofing		1996	54,022		15	3,601	3,601	12,154	16
17	Fire & security alarm		1997	4,110		15	274	274	925	17
18	Paint & wallpaper		1997	3,082		15	205	205	693	18
19	Hinges & doors		1997	6,284		15	419	419	1,414	19
20	Tile		1997	10,739		15	716	716	2,416	20
21	Garage & ground prep		1997	10,489		15	699	699	2,359	21
22	Roofing		1997	7,202		15	480	480	1,620	22
23	Handrail		1997	10,900		15	727	727	2,454	23
24	HVAC		1997	27,483		15	1,833	1,833	6,185	24
25	Drivivt		1997	13,900		15	927	927	3,129	25
26	Plumbing & electric		1997	21,742		15	1,449	1,449	4,891	26
27	Architecture costs		1997	1,986		15	132	132	446	27
28	Flooring		1997	700		15	47	47	117	28
29	Remodeling of facility		1997	18,980		15	1,265	1,265	3,163	29
30	A/C Timer		1997	2,338		15	156	156	390	30
31	Painting		1997	5,792		15	386	386	965	31
32	Landscaping		1997	6,430		15	429	429	1,072	32
33	Lockset, passage set		1997	9,104		15	607	607	1,517	33
34	Electrical service		1997	8,704		15	580	580	1,450	34
35										35
36	TOTAL (lines 4 thru 35)			\$ 2,319,230	\$		\$ 69,935	\$ 69,935	\$ 354,088	36

\*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number Casey Care Center

# 0039800

Report Period Beginning:

7/1/99

Ending:

6/30/00

## XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Bed* <sup>s</sup>	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		Ceiling Tiling	1997		3,762		15	251	251	627	9
10		Doors	1997		8,000		15	532	532	1,331	10
11		Remodeling of bathroom	1998		4,149		15	277	277	692	11
12		Remodeling of facility	1998		12,277		15	818	818	2,045	12
13		Painting	1998		2,541		15	169	169	423	13
14		Tiling	1998		2,205		15	147	147	368	14
15		Flooring	1998		27,771		15	1,851	1,851	4,628	15
16		Painting and Wallpaper	1998		2,912		15	194	194	485	16
17		Light Fixtures	1998		931		15	62	62	155	17
18		Cabinet/Drawers/Countertops	1998		1,401		15	93	93	233	18
19		Fence	1998		9,613		15	641	641	1,602	19
20		Piping	1998		168		15	11	11	28	20
21		Windows	1998		430		15	29	29	72	21
22		Security	1998		16,030		15	1,069	1,069	2,672	22
23		Architecture Services	1998		270		15	18	18	45	23
24		Signs	1998		3,500		15	233	233	583	24
25		Sidewalk	1998		720		15	48	48	120	25
26		Awning	1998		4,937		15	369	369	534	26
27		Nurse Station Shelving	1998		541		15	36	36	54	27
28		Landscaping	1998		1,614		15	108	108	162	28
29		Carpeting	1998		1,715		15	114	114	171	29
30		Air Conditioner Enclosures	1998		1,806		15	120	120	180	30
31		Sidewalk	1998		3,621		15	242	242	363	31
32		Beauty Shop Renovation	1998		623		15	42	42	63	32
33		Panic Bar	1998		279		15	19	19	28	33
34		Fountain	1998		290		15	20	20	30	34
35		Alarm Door Controller	1998		325		15	22	22	33	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 112,431	\$		\$ 7,535	\$ 7,535	\$ 17,727	36

\*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Casey Care Center

# 0039800

Report Period Beginning:

7/1/99

Ending:

6/30/00

**XI. OWNERSHIP COSTS (continued)**

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		Light & related renovation	1998		963		15	64	64	96	9
10		Landscaping	1998		3,447		15	230	230	345	10
11		Grab bar, sink	1999		401		15	27	27	40	11
12		Annunciator @ nursing station	1999		2,500		15	167	167	250	12
13		Ceiling tiles	1999		416		15	28	28	42	13
14		Drywall renovation	1999		1,930		15	129	129	193	14
15		Lavatory	1999		300		15	20	20	30	15
16		Lavatory	1999		324		15	22	22	33	16
17		Lighting	1999		983		15	66	66	99	17
18		Kitchen cabinets	1999		1,291	86	15	86		129	18
19		Asphalt resurfacing	1999		10,259		15	684	684	1,026	19
20		Door frames & accessories	1999		1,238	42	15	42		42	20
21		Insinkerator	1999		962	32	15	32		32	21
22		Painting and remodeling	2000		13,699		15	457	457	457	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		<b>TOTAL (lines 4 thru 35)</b>			\$ 38,713	\$ 160		\$ 2,054	\$ 1,894	\$ 2,814	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 ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

# 0039800

Report Period Beginning:

7/1/99

Ending:

6/30/00

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	
37	Purchased in Prior Years	\$ 411,665	\$ 4,737	\$ 39,542	\$ 34,805	5-10 yrs	\$ 175,638	37
38	Current Year Purchases	37,102	238	1,855	1,617	5-10 yrs	1,855	38
39	Fully Depreciated Assets							39
40	Parent and management company allocation			4,907	4,907			40
41	TOTALS	\$ 448,767	\$ 4,975	\$ 46,304	\$ 41,329		\$ 177,493	41

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	
42	Resident transportation	1997 Ford E150*	1997	\$ 21,597	\$	\$ 7,199	\$ 7,199	3	\$ 21,597	42
43	Resident transportation	1997 GMC Van*	1998	5,315	1,772	1,772		3	2,658	43
44		*Cost allocated between 3 facilities								44
45										45
46	TOTALS			\$ 26,912	\$ 1,772	\$ 8,971	\$ 7,199		\$ 24,255	46

E. Summary of Care-Related Assets

		Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,056,053	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 6,907	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 134,799	49
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 127,892	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 576,377	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center# 0039800Report Period Beginning: 7/1/99Ending: 6/30/00**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: N/A

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 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Parent and management company allocation:				9,180			6
7	TOTAL				\$ 9,180			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 N/A.N/AN/A9. Option to Buy: 

YES

NO

Terms: N/A

\*

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

15. Is Movable equipment rental included in building rental?

 YES  NO16. Rental Amount for movable equipment: \$ 12,558Description: Dishwasher-\$1,876; Trailer-\$609; Cooler-\$114; Management Co. Allocation-\$9,959  
(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	Resident &	96 Chevrolet Lumina	\$ 225.53	\$ 2,706	17
18	administrative	91 Ford Taurus Wagon	175.92	2,111	18
19					19
20	Management company allocation:			17	20
21	TOTAL		\$ 401.45	\$ 4,834	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. /2001 \$ \_\_\_\_\_13. /2002 \$ \_\_\_\_\_14. /2003 \$ \_\_\_\_\_\* 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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p><i>It is the policy of this facility to only hire certified nurses aides.</i></p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: _____</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		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	Nurse Aide 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 aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

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

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide 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 aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides 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 aides.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Part B MCR Supplies	L39, C8					1,906		1,906	13
14	TOTAL			\$		\$	1,906	\$	1,906	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 nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Casey Care Center

# 0039800

Report Period Beginning: 7/1/99

Ending:

6/30/00

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 6/30/00

(last day of reporting year)

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

	1	2	
	Operating	After Consolidation*	
<b>A. Current Assets</b>			
1 Cash on Hand and in Banks	\$	\$	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance <u>20,502</u> )	76,696	76,696	3
4 Supply Inventory (priced at _____ )			4
5 Short-Term Investments			5
6 Prepaid Insurance	34	34	6
7 Other Prepaid Expenses	8,939	8,939	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): <u>Due to/from G&amp;T Resources</u>	887	887	9
10 <b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 86,556	\$ 86,556	10
<b>B. Long-Term Assets</b>			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		110,000	13
14 Buildings, at Historical Cost		2,032,485	14
15 Leasehold Improvements, at Historical Cost	3,490	437,889	15
16 Equipment, at Historical Cost	40,954	475,679	16
17 Accumulated Depreciation (book methods)	(13,027)	(576,377)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	4,176	4,176	19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify): _____			22
23 Other(specify): <u>Investment in subsidiary</u>	2,485	2,485	23
24 <b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 38,078	\$ 2,486,337	24
25 <b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 124,634	\$ 2,572,893	25

	1	2	
	Operating	After Consolidation*	
<b>C. Current Liabilities</b>			
26 Accounts Payable	\$ 119,530	\$ 119,530	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	69,008	69,008	30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>			
36 <u>See Attached Schedule 17A</u>	110,892	110,892	36
37 <u>Due to Related Parties</u>	1,297,893	1,297,893	37
38 <b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,597,323	\$ 1,597,323	38
<b>D. Long-Term Liabilities</b>			
39 Long-Term Notes Payable	21,751	3,293,628	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>			
43			43
44			44
45 <b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 21,751	\$ 3,293,628	45
46 <b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,619,074	\$ 4,890,951	46
47 <b>TOTAL EQUITY(page 18, line 24)</b>	\$ (1,494,440)	\$ (2,318,058)	47
48 <b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 124,634	\$ 2,572,893	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Casey Care Center  
Provider #0039800  
June 30, 2000**

**Schedule 17A**

XV. Balance Sheet

<u>Line 36 - Other</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Expense	1,889	1,889
Accrued Legal & Accounting	21,442	21,442
Accrued Rent	43,979	43,979
Accrued Participation	14,469	14,469
Accrued Insurance	24,631	24,631
Wage Assignment	393	393
Resident Credit Balances	4,089	4,089
	<u>110,892</u>	<u>110,892</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (961,807)	1
2	Restatements (describe):		2
3	Prior period audit adjustments	4,166	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (957,641)	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	(423,631)	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 Parent & management company allocation		15
16	Other (describe added back in column 7	(113,168)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (536,799)	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,494,440)	24 *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 1,781,524	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,781,524	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,882	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	698	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 4,580	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	182	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 182	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Vending Income</b>	1,158	28
28a	<b>Miscellaneous Income</b>	3,633	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,791	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,791,077	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	454,080	31
32	Health Care	816,779	32
33	General Administration	505,938	33
<b>B. Capital Expense</b>			
34	Ownership	374,848	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	4,869	35
36	Provider Participation Fee	58,194	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,214,708	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(423,631)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (423,631)	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. A federal tax return is filed for the combined divisions of Caravilla Resident Centers, Inc.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Casey Care Center

# 0039800

Report Period Beginning: 7/1/99

Ending: 6/30/00

**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	2,028	\$ 35,658	\$ 17.58	1
2	Assistant Director of Nursing				2
3	Registered Nurses	4,551	61,767	12.51	3
4	Licensed Practical Nurses	12,547	142,710	10.56	4
5	Nurse Aides & Orderlies	56,196	415,783	6.98	5
6	Nurse Aide Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides	1,888	15,318	7.38	8
9	Activity Director				9
10	Activity Assistants	2,914	20,083	6.43	10
11	Social Service Workers	2,440	19,602	7.79	11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants	15,333	100,247	6.06	15
16	Dishwashers				16
17	Maintenance Workers	2,949	30,929	10.20	17
18	Housekeepers	12,330	78,091	5.94	18
19	Laundry	4,258	26,302	5.63	19
20	Administrator	1,984	40,832	19.33	20
21	Assistant Administrator				21
22	Other Administrative	1,722	41,272	23.17	22
23	Office Manager				23
24	Clerical	7,484	152,239	19.43	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	633	3,723	5.88	31
32	Other Health Care: See Sch 20A	4,739	56,043	11.13	32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)	133,996	\$ 1,240,599 *	\$ 8.70	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	90	\$ 4,545	L1,C3	35
36	Medical Director	Monthly	6,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	371	L10,C3	38
39	Pharmacist Consultant	Monthly	164	L10,C3	39
40	Physical Therapy Consultant	11	328	L10A,C3	40
41	Occupational Therapy Consultant	7	216	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	20	2,466	L11,C8	44
45	Social Service Consultant	36	1,946	L12,C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	164	\$ 16,036		49

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Casey Care Center**  
**Provider #0039800**  
**June 30, 2000**

**Schedule 20A**

Schedule XVIII - Staffing & Salary Costs  
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Amount	Ave Hrly Wage
Care Plan Coordinator	2,002	2,122	22,847	10.77
Ancillary Clerk	44	93	617	6.63
Alzheimer's Manager	2,693	2,822	32,579	11.54
	<u>4,739</u>	<u>5,037</u>	<u>56,043</u>	<u>11.13</u>

See Accountants' Compilation Report



Casey Care Center  
Provider #0039800  
June 30, 2000

Schedule 21C

XIX. Support Schedules  
Section C. Professional Services

<b>TOTAL (agree to Schedule V, line 19, column 3)</b>		<b>51,565</b>
Caravilla Charitable Corporation:		
Altschuler, Melvoin & Glasser LLP	Accounting	6,039
American Express Tax & Business Services	Accounting	744
Mangum, Smietanka & Johnson	Legal	362
Management Company Allocation		
American Express Tax & Business Services	Accounting	507
Altschuler, Melvoin & Glasser LLP	Accounting	3,083
Mangum, Smietanka & Johnson	Legal	5,307
Parent Company Allocation:		
American Express Tax & Business Services	Accounting	5,278
Altschuler, Melvoin & Glasser LLP	Accounting	10,019
ADP	Payroll Processing	17,155
Health Outcomes	Consulting	2,190
Corporate Allocation:		
Altschuler, Melvoin & Glasser LLP	Accounting	3,834
American Express Tax & Business Services	Accounting	837
Mangum, Smietanka & Johnson	Legal	1,548
Total adjustments & allocations		<u>56,903</u>
<b>TOTAL (agree to Schedule V, line 19, column 8)</b>		<b><u>108,468</u></b>

SEE ACCOUNTANTS' COMPILATION REPORT

CASEY CARE CENTER  
PROVIDER #0039800  
6/30/2000

LINE 24 DETAIL:

EDUCATION/SEMINARS	4,454
CNA EDUCATION EXPENSE	1,758
ADMIN TRAVEL	277
ADMIN MEALS	112
ADMIN LODGING	1,128
SEMINAR TRAVEL	916
SEMINAR MEALS	1,950
SEMINAR LODGING	1,191
	<hr/>
	11,786
PARENT COMPANY ALLOCATION	1,497
MANAGEMENT COMPANY ALLOCATION	7,204
	<hr/>
	<u>\$ 20,487</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

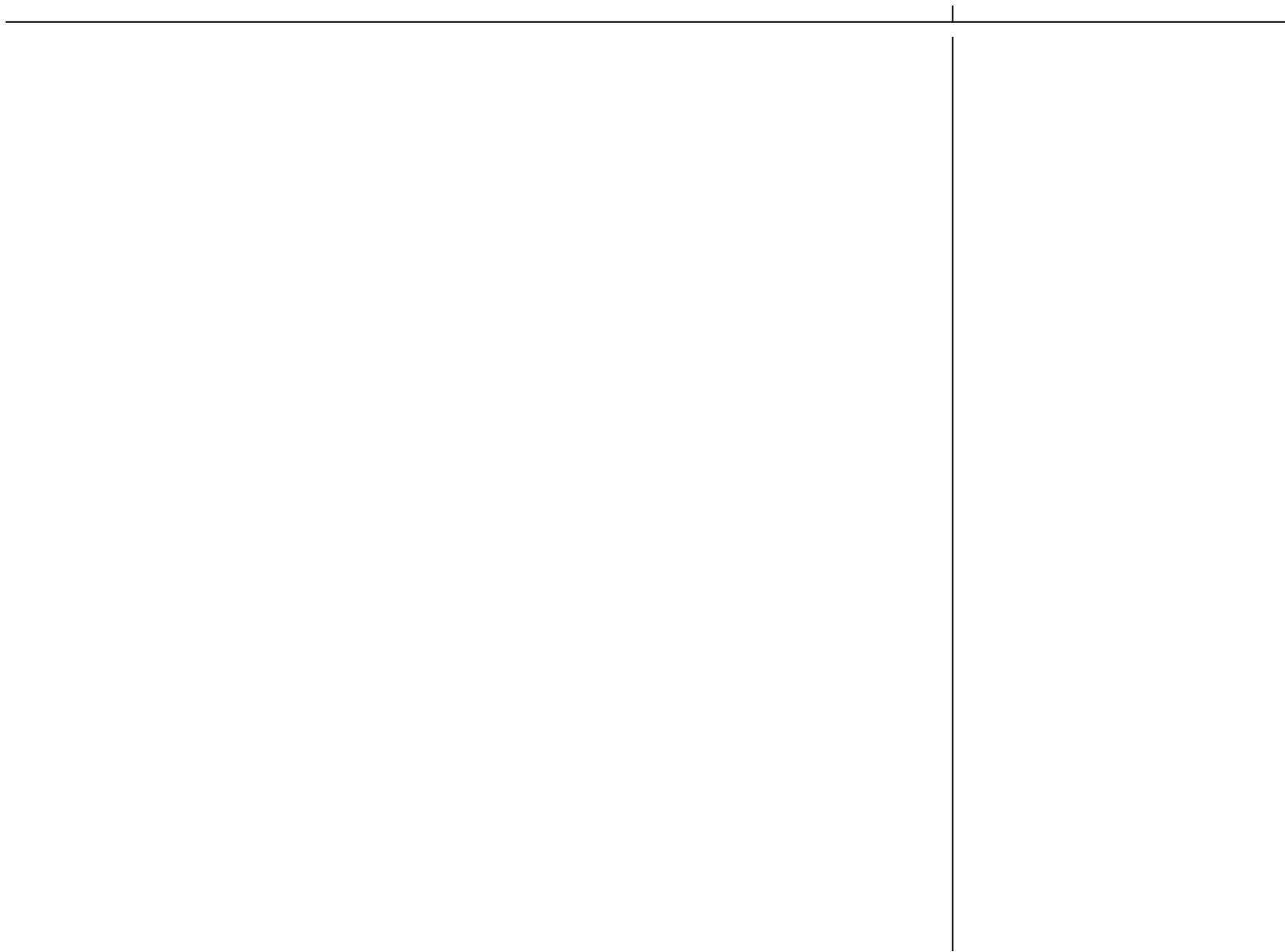
1	2	3	4	5										6	7	8	9	10	11	12	13
				Amount of Expense Amortized Per Year																	
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005									
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$									
2																					
3																					
4																					
5																					
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18																					
19																					
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$									

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Health Care Association -\$4,120
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (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? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line N/A
- (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 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 58,194  
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 of Public Aid, 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. \$ 14,702 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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? 41%  
d. Have vehicle usage logs been maintained? Adequate records are maintained  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
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: Altschuler, Melvojn & Glasser LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, 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.

SEE ACCOUNTANTS' COMPILATION REPORT



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