

		FOR OHF USE				

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

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.

<p>I. IDPH Facility ID Number: <u>0039800</u></p> <p>Facility Name: <u>Casey Care Center</u></p> <p>Address: <u>5 Doctors Park</u> <u>Mount Vernon</u> <u>62864</u> Number City Zip Code</p> <p>County: <u>Jefferson</u></p> <p>Telephone Number: <u>(618) 242-1064</u> Fax # <u>(618) 242-7559</u></p> <p>IDPA ID Number: <u>391516877001</u></p> <p>Date of Initial License for Current Owners: <u>10/01/94</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (c) (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other</td> <td>_____</td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Christine Hanover</u> Telephone Number: <u>(312) 384-6000</u> Please send copies of desk review and audit adjustments to address on this page</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (c) (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust	_____		<input type="checkbox"/> Other	_____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/03</u> to <u>06/30/04</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1155 673 1291 820">Officer or Administrator of Provider</td> <td data-bbox="1291 673 1950 738">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1155 738 1291 820"></td> <td data-bbox="1291 738 1950 803">(Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td data-bbox="1155 820 1291 1031">Paid Preparer</td> <td data-bbox="1291 820 1950 885">(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td data-bbox="1155 885 1291 1031"></td> <td data-bbox="1291 885 1950 933">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1155 933 1291 1031"></td> <td data-bbox="1291 933 1950 998">(Firm Name & Address) <u>Altschuler, Melvoim and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></td> </tr> <tr> <td data-bbox="1155 998 1291 1031"></td> <td data-bbox="1291 998 1950 1031">(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____		(Print Name and Title) _____		(Firm Name & Address) <u>Altschuler, Melvoim and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>		(Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

0039800 Report Period Beginning: 07/01/03 Ending: 06/30/04

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 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		2 Public Aid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	18,839	5,012		23,851	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,839	5,012		23,851	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.48%

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 10/01/1994

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 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 06/30/04 Fiscal Year: 06/30/04

* 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: 07/01/03 Ending: 06/30/04

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

	Operating Expenses	Costs Per General Ledger				Reclassification 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
A. General Services											
1	Dietary	95,652	7,757	5,135	108,544		108,544		108,544		1
2	Food Purchase		102,238		102,238		102,238	(16,659)	85,579		2
3	Housekeeping	79,348	12,172		91,520		91,520		91,520		3
4	Laundry	35,301	13,584		48,885		48,885		48,885		4
5	Heat and Other Utilities			56,114	56,114		56,114		56,114		5
6	Maintenance	16,151		31,841	47,992		47,992		47,992		6
7	Other (specify):*										7
8	TOTAL General Services	226,452	135,751	93,090	455,293		455,293	(16,659)	438,634		8
B. Health Care and Programs											
9	Medical Director			6,100	6,100		6,100		6,100		9
10	Nursing and Medical Records	806,071	32,249	632	838,952		838,952		838,952		10
10a	Therapy			120	120		120		120		10a
11	Activities	20,351	4,735	2,297	27,383		27,383		27,383		11
12	Social Services	17,330	22	697	18,049		18,049		18,049		12
13	Nurse Aide Training										13
14	Program Transportation			1,003	1,003		1,003		1,003		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	843,752	37,006	10,849	891,607		891,607		891,607		16
C. General Administration											
17	Administrative	45,277		123,000	168,277		168,277		168,277		17
18	Directors Fees										18
19	Professional Services			2,641	2,641		2,641	20,068	22,709		19
20	Dues, Fees, Subscriptions & Promotions			8,920	8,920		8,920	194	9,114		20
21	Clerical & General Office Expenses	20,884	4,164	21,449	46,497		46,497	2,226	48,723		21
22	Employee Benefits & Payroll Taxes			116,572	116,572		116,572	79,948	196,520		22
23	Inservice Training & Education			102	102		102		102		23
24	Travel and Seminar			4,385	4,385		4,385	194	4,579		24
25	Other Admin. Staff Transportation			850	850		850		850		25
26	Insurance-Prop.Liab.Malpractice			(1)	(1)		(1)	68,264	68,263		26
27	Other (specify):*										27
28	TOTAL General Administration	66,161	4,164	277,918	348,243		348,243	170,894	519,137		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,136,365	176,921	381,857	1,695,143		1,695,143	154,235	1,849,378		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.

Facility Name & ID Number

Casey Care Center

#0039800

Report Period Beginning:

07/01/03

Ending:

06/30/04

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	
	D. Ownership											
30	Depreciation			9,585	9,585		9,585	122,558	132,143			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,088	1,088		1,088	279,913	281,001			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			424,902	424,902		424,902	(424,902)				34
35	Rent-Equipment & Vehicles			1,481	1,481		1,481		1,481			35
36	Other (specify):*											36
37	TOTAL Ownership			437,056	437,056		437,056	(22,431)	414,625			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											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			12,185	12,185		12,185	(12,185)				43
44	TOTAL Special Cost Centers			70,379	70,379		70,379	(12,185)	58,194			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,136,365	176,921	889,292	2,202,578		2,202,578	119,619	2,322,197			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

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	(538)	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	6,327	30		9
10	Interest and Other Investment Income	(290)	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	(3,926)	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	(8,150)	43		18
19	Entertainment				19
20	Contributions	(195)	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	(2,454)	43		24
25	Fund Raising, Advertising and Promotional	(675)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(173)	43		28
29	Other-Attach Schedule See attached Schedule 5A	(1,929)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (12,003)		\$	30

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)	131,622		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 131,622		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 119,619		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center
Provider #: 0039800
07/01/03 to 06/30/04

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
Nonallowable collection fees	(1,021)	19
Miscellaneous income offset	<u>(908)</u>	21
Total	<u><u>(1,929)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Care Center

ID# 0039800

Report Period Beginning: 07/01/03

Ending: 06/30/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			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	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Casey Care Center

0039800

Report Period Beginning:

07/01/03

Ending:

06/30/04

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	21,089	0	0	0	0	0	0	0	0	0	21,089	19
20	Fees, Subscriptions & Promotions	0	184	10	0	0	0	0	0	0	0	0	194	20
21	Clerical & General Office Expenses	0	3,134	0	0	0	0	0	0	0	0	0	3,134	21
22	Employee Benefits & Payroll Taxes	0	63,289	0	0	0	0	0	0	0	0	0	63,289	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	194	0	0	0	0	0	0	0	0	0	194	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	68,264	0	0	0	0	0	0	0	0	0	68,264	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	156,154	10	0	0	0	0	0	0	0	0	156,164	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	156,154	10	0	0	0	0	0	0	0	0	156,164	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Casey Care Center

0039800

Report Period Beginning:

07/01/03

Ending:

06/30/04

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	6,327	0	116,231	0	0	0	0	0	0	0	0	122,558	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,216)	2,828	281,301	0	0	0	0	0	0	0	0	279,913	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(424,902)	0	0	0	0	0	0	0	0	(424,902)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	2,111	2,828	(27,370)	0	(22,431)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(12,185)	0	0	0	0	0	0	0	0	0	0	(12,185)	43
44	TOTAL Special Cost Centers	(12,185)	0	0	0	0	0	0	0	0	0	0	(12,185)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(10,074)	158,982	(27,360)	0	121,548	45							

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Residential Centers, Inc.	100%	Mt. Vernon Care Center	Mt. Vernon	Caravilla Charitable	Mt. Vernon	Lessor
		Jeffersonian Care Center	Mt. Vernon	Corporation		
Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions with the nursing home during the reporting period						

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	24 Board member travel	\$	Caravilla Residential Centers, Inc.	100.00%	\$ 194	\$ 194
2	V	19 Professional fees		Caravilla Residential Centers, Inc.	100.00%	21,089	21,089
3	V	20 Licenses, dues & subscriptions		Caravilla Residential Centers, Inc.	100.00%	184	184
4	V	21 Office supplies & telephone		Caravilla Residential Centers, Inc.	100.00%	3,134	3,134
5	V	22 Emp. Benefits & payroll taxes		Caravilla Residential Centers, Inc.	100.00%	63,289	63,289
6	V	26 Vehicle, fire & liab. insurance		Caravilla Residential Centers, Inc.	100.00%	68,264	68,264
7	V	32 Interest expense		Caravilla Residential Centers, Inc.	100.00%	2,828	2,828
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$ 158,982	\$ * 158,982

* 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 Schedule V	2 Line	3 Cost Per General Ledger		4 Amount	5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization		8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item			Name of Related Organization						
15	V	20	Licenses, dues & subscriptions	\$	Caravilla Charitable Corporation	**	\$ 10	\$ 10		15	
16	V	30	Depreciation		Caravilla Charitable Corporation	**	116,231	116,231		16	
17	V	32	Interest expense		Caravilla Charitable Corporation	**	281,301	281,301		17	
18	V	34	Rent expense	424,902	Caravilla Charitable Corporation	**			(424,902)	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				**Caravilla Charitable Corporation and Caravilla Residential Centers, Inc. have the same board of directors.					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			\$ 424,902			\$ 397,542	\$ *	(27,360)	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: 07/01/03 Ending: 06/30/04

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	None	2 hrs/mtg.		none	\$ 0	1
2	Roger Ryan	Vice President	Board Member	None	None	2 hrs/mtg.		none	0	2
3	William Armstrong	Treasurer	Board Member	None	None	2 hrs/mtg.		none	0	3
4	Kay Baker	Secretary	Board Member	None	None	2 hrs/mtg.		none	0	4
5	Ronald O'Daniell	Director	Board Member	None	None	2 hrs/mtg.		none	0	5
6									0	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/03 Ending: 06/30/04

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 Residential Centers, Inc.
 Street Address 2020 W. War Memorial Dr., Suite 302
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 685-0595
 Fax Number (309) 685-9596

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	24	Board member travel	Number of beds	235	3	\$ 430	106	\$ 194	1
2	19	Professional fees	Number of beds	235	3	46,754	106	21,089	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	408	106	184	3
4	21	Office supplies & telephone	Number of beds	235	3	7,744	106	3,134	4
5	32	Interest expense	Number of beds	235	3	6,270	106	2,828	5
6									6
7									7
8									8
9									9
10	22	Emp. benefits & payroll taxes	Direct method					63,289	10
11	26	Vehicle, fire & liab. insurance	Direct method					68,264	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					\$ 61,606	\$	\$ 158,982	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center # 0039800 Report Period Beginning: 07/01/03 Ending: 06/30/04

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									
	A. Directly Facility Related											
	Long-Term											
1	NCS Healthcare, Inc.		X	Hardware/Software	\$728.00	10/31/98	\$ 29,136	\$ 6,380	01/01/04	0.1429	\$	1
2	Continental Wingate		X	Purchase Facility	\$55,560.00	09/16/96	7,402,500	3,236,431	10/01/31	0.0855	276,715	2
3												3
4												4
5							Amortization Expense				4,291	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$56,288.00		\$ 7,431,636	\$ 3,242,811			\$ 281,006	9
	B. Non-Facility Related*											
10										Finance Charge	3,916	10
11										Offset on interest income	(290)	11
12										Non-allowable finance char	(3,926)	12
13										Parent company allocation	295	13
14	TOTAL Non-Facility Related						\$	\$			\$ (5)	14
15	TOTALS (line 9+line14)						\$ 7,431,636	\$ 3,242,811			\$ 281,001	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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2003 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).		\$ N/A	3																								
4. Real Estate Tax accrual used for 2004 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. (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.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1999</td><td>8</td></tr> <tr><td>2000</td><td>9</td></tr> <tr><td>2001</td><td>10</td></tr> <tr><td>2002</td><td>11</td></tr> <tr><td>2003</td><td>12</td></tr> </table>	1999	8	2000	9	2001	10	2002	11	2003	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2003 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2003 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1999	8																										
2000	9																										
2001	10																										
2002	11																										
2003	12																										
FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2003 \$	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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Casey Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039800

CONTACT PERSON REGARDING THIS REPORT Allan Herrmann

TELEPHONE (309) 685-0595 FAX #: (309) 685-9596

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200:

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (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 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

0039800 Report Period Beginning:

07/01/03 Ending: 06/30/04

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 ground: (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	TOTALS	120,000		\$ 110,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

0039800

Report Period Beginning:

07/01/03

Ending:

06/30/04

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	\$ 493,817	4
5		1998	1998	6,585		40	165	165	1,072	5
6										6
7										7
8										8
Improvement Type**										
9	Building Improvements		1995	2,586		15	172	172	1,628	9
10	4 doors		1995	715		15	48	48	384	10
11	3 furnaces, 2 a/c's, 3 coils		1995	14,366		15	958	958	7,664	11
12	Windows		1996	20,184		15	1,346	1,346	9,927	12
13	Fire & security alarms		1996	9,560		15	637	637	4,698	13
14	Architecture costs		1996	7,939		15	529	529	3,901	14
15	Asphalt & sidewalk		1996	7,408		15	500	500	3,649	15
16	Roofing		1996	54,022		15	3,601	3,601	26,558	16
17	Fire & security alarm		1997	4,110		15	274	274	2,021	17
18	Paint & wallpaper		1997	3,082		15	205	205	1,513	18
19	Hinges & doors		1997	6,284		15	419	419	3,090	19
20	Tile		1997	10,739		15	716	716	5,280	20
21	Garage & ground prep		1997	10,489		15	699	699	5,155	21
22	Roofing		1997	7,202		15	480	480	3,540	22
23	Handrail		1997	10,900		15	727	727	5,362	23
24	HVAC		1997	27,483		15	1,833	1,833	13,517	24
25	Dryvit		1997	13,900		15	927	927	6,837	25
26	Plumbing & electrical		1997	21,742		15	1,449	1,449	10,687	26
27	Architecture costs		1997	1,986		15	132	132	974	27
28	Flooring		1997	700		15	47	47	305	28
29	Remodeling of facility		1997	18,980		15	1,265	1,265	8,223	29
30	A/C Timer		1997	2,338		15	156	156	1,014	30
31	Painting		1997	5,792		15	386	386	2,509	31
32	Landscaping		1997	6,430		15	429	429	2,788	32
33	Lockset, passage set		1997	9,104		15	607	607	3,945	33
34	Electrical service		1997	8,704		15	580	580	3,770	34
35	Ceiling Tiling		1997	3,762		15	251	251	1,631	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center

0039800

Report Period Beginning:

07/01/03

Ending:

06/30/04

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Doors	1997	\$ 8,000	\$	15	\$ 532	\$ 532	\$ 3,459		37
38	Remodeling of bathroom	1998	4,149		15	277	277	1,800		38
39	Remodeling of facility	1998	12,277		15	818	818	5,317		39
40	Painting	1998	2,541		15	169	169	1,099		40
41	Tiling	1998	2,205		15	147	147	956		41
42	Flooring	1998	27,771		15	1,851	1,851	12,032		42
43	Painting and Wallpaper	1998	2,912		15	194	194	1,261		43
44	Light Fixtures	1998	931		15	62	62	403		44
45	Cabinets/Drawers/Countertops	1998	1,401		15	93	93	605		45
46	Fence	1998	9,613		15	641	641	4,166		46
47	Piping	1998	168		15	11	11	72		47
48	Windows	1998	430		15	29	29	188		48
49	Security	1998	16,030		15	1,069	1,069	6,948		49
50	Architecture Services	1998	270		15	18	18	117		50
51	Signs	1998	3,500		15	233	233	1,515		51
52	Sidewalk	1998	720		15	48	48	312		52
53	Awning	1998	4,937		15	369	369	2,010		53
54	Nurse Station Shelving	1998	541		15	36	36	198		54
55	Landscaping	1998	1,614		15	108	108	594		55
56	Carpeting	1998	1,715		15	114	114	627		56
57	Air Conditioner Enclosures	1998	1,806		15	120	120	660		57
58	Sidewalk	1998	3,621		15	242	242	1,331		58
59	Beauty Shop Renovation	1998	623		15	42	42	231		59
60	Panic Bar	1998	279		15	19	19	104		60
61	Fountain	1998	290		15	20	20	110		61
62	Alarm Door Controller	1998	325		15	22	22	121		62
63	Light & related renovation	1998	963		15	64	64	352		63
64	Landscaping	1998	3,447		15	230	230	1,265		64
65	Grab bar, sink	1998	401		15	27	27	148		65
66	Annunciator @ nursing station	1999	2,500		15	167	167	918		66
67	Ceiling Tiles	1999	416		15	28	28	154		67
68	Drywall renovation	1999	1,930		15	129	129	709		68
69	Lavatory	1999	300		15	20	20	110		69
70	TOTAL (lines 4 thru 69)		\$ 2,441,618	\$		\$ 78,135	\$ 78,135	\$ 685,351		70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,441,618	\$		\$ 78,135	\$ 78,135	\$ 685,351	1
2	Lavatory	1999	324		15	22	22	121	2
3	Lighting	1999	983		15	66	66	363	3
4	Kitchen cabinets	1999	1,291	86	15	86		473	4
5	Asphalt resurfacing	1999	10,259		15	684	684	3,762	5
6	Door frames & accessories	1999	1,238	83	15	83		374	6
7	Insinkerator	1999	962	64	15	64		288	7
8	Painting and remodeling	2000	13,699		15	913	913	4,109	8
9	Hot water line	2000	2,569	171	15	171		514	9
10	Laundry room remodeling	2000	1,400	93	15	93		280	10
11	Moulding	2001	773	51	15	51		179	11
12	Moulding	2001	631	42	15	42		147	12
13	A/C condensor	2001	1,445	96	15	96		336	13
14	Labor for building improvements	2000	23,139		15	1,543	1,543	6,172	14
15	Water Heater	2002	2,739	183	15	183		457	15
16	Rolling steel fire door	2003	2,874	96	15	96		96	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	TOTAL (lines 1 thru 33)		\$ 2,505,944	\$ 965		\$ 82,328	\$ 81,363	\$ 703,022	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 470,179	\$ 5,543	\$ 46,739	\$ 41,196	5-10 years	\$ 370,820	71
72	Current Year Purchases	13,339	620	620		10 years	620	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 483,518	\$ 6,163	\$ 47,359	\$ 41,196		\$ 371,440	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident transportation	1997 Ford E150***	1997	\$ 21,597	\$	\$	\$	3	\$ 21,597	76
77	Resident transportation	1995 Chevy Corsica***	2002	1,522	507	507		3	1,267	77
78	Resident transportation	1997 Ford Taurus***	2002	3,044	1,016	1,016		3	2,539	78
79	Resident transportation	1992 Chevy Van***	2002	2,801	933	933		3	2,333	79
80	TOTALS			\$ 28,964	\$ 2,456	\$ 2,456	\$		\$ 27,736	80

*** Cost allocated between 3 facilities

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)	\$ 3,128,426	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 9,584	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 132,143	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 122,559	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,102,198	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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.	<u>/2005</u>	\$ _____
13.	<u>/2006</u>	\$ _____
14.	<u>/2007</u>	\$ _____

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/A

9. 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 NO
 16. Rental Amount for movable equipment: \$ 1,481 Description: See attached Schedule 14A
 (Attach a schedule detailing the breakdown of movable equipment)

* 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.

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

Casey Care Center

Provider #: 0039800

07/01/03 to 06/30/04

Schedule 14A

XII. Rental Costs

Part B. Equipment-Excluding Transportation and Fixed Equipment

Line 16. Rental Amount for Movable Equipment

<u>Description</u>	<u>Amount</u>
Dishwasher	12
Copier	678
File Storage	514
Chaffing Dishes	70
Postage Meter	30
U-Haul	<u>177</u>
Total	<u><u>1,481</u></u>

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? 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.</p>	<p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>	<p>2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____</p>
---	---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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.

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)	
TOTAL TRAINED	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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):												13	
14	TOTAL			\$		\$		\$			\$		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

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Casey Care Center

0039800

Report Period Beginning: 07/01/03

Ending:

06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/04

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 53,372	\$ 53,372	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 20,502)	113,761	113,761	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,465	28,465	6
7	Other Prepaid Expenses	193	193	7
8	Accounts Receivable (owners or related parties)	293,000	293,000	8
9	Other(specify): Prepaid Deposit	7,642	7,642	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 496,433	\$ 496,433	10
B. Long-Term Assets				
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	15,921	473,459	15
16	Equipment, at Historical Cost	70,961	512,482	16
17	Accumulated Depreciation (book methods)	(43,031)	(1,102,198)	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 (specify):			22
23	Other(specify): Investment in subsidiary	2,485	2,485	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,336	\$ 2,028,713	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 542,769	\$ 2,525,146	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 266,624	\$ 266,624	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,675	67,675	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
Other Current Liabilities(specify):				
36	See Schedule 17A	2,483,424	978,562	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,817,723	\$ 1,312,861	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	6,380	3,242,811	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)	\$ 6,380	\$ 3,242,811	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,824,103	\$ 4,555,672	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,281,334)	\$ (2,030,526)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 542,769	\$ 2,525,146	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Casey Care Center
Provider #0039800
June 30, 2004

Schedule 17A

XV. Balance Sheet

<u>Line 36-Other</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Expense	5,529	5,529
Resident Credit Balances	4,089	4,089
Due to related party	1,115,302	1,115,302
Accrued Rent	1,327,819	(177,043)
Accrued Participation Fees	14,469	14,469
Accrued Insurance	16,216	16,216
	<u>2,483,424</u>	<u>978,562</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,769,579)	1
2	Restatements (describe):		2
3	Prior period audit adjustments	37,212	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,732,367)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(389,985)	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) Certain expense allocations		15
16	Other (describe) added back in column 7	(158,982)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (548,967)	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)	\$ (2,281,334)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Casey Care Center

0039800

Report Period Beginning: 07/01/03

Ending:

Page 19

06/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,806,345	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,806,345	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,308	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	1,787	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 4,095	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	285	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 285	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule 19a	1,868	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,868	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,812,593	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	455,293	31
32	Health Care	891,607	32
33	General Administration	348,243	33
B. Capital Expense			
34	Ownership	437,056	34
C. Ancillary Expense			
35	Special Cost Centers	12,185	35
36	Provider Participation Fee	58,194	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,202,578	40
41	Income before Income Taxes (line 30 minus line 40)**	(389,985)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (389,985)	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 Residential 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.

**Casey Care Center
Provider #0039800
June 30, 2004**

Schedule 19A

XVII. Income Statement
Line 28: Other

Description	Amount
Vending Income	960
Miscellaneous Income	<u>908</u>
Total	<u><u>1,868</u></u>

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center

0039800

Report Period Beginning: 07/01/03

Ending:

06/30/04

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	2,159	2,285	\$ 37,508	\$ 16.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,657	4,954	79,222	15.99	3
4	Licensed Practical Nurses	11,650	12,342	162,609	13.18	4
5	Nurse Aides & Orderlies	55,661	59,412	456,704	7.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,756	1,987	16,914	8.51	8
9	Activity Director					9
10	Activity Assistants	3,078	3,198	20,351	6.36	10
11	Social Service Workers	1,934	2,088	17,330	8.30	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,490	15,406	95,652	6.21	15
16	Dishwashers					16
17	Maintenance Workers	1,897	2,025	16,151	7.98	17
18	Housekeepers	12,497	13,398	79,348	5.92	18
19	Laundry	5,501	5,983	35,301	5.90	19
20	Administrator	1,535	1,807	45,277	25.06	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,992	2,112	20,884	9.89	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	1,031	1,051	6,698	6.37	31
32	Other Health Care See Sch. 20A	3,972	4,212	46,416	11.02	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,810	132,260	\$ 1,136,365 *	\$ 8.59	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	102	\$ 5,135	L1, C3	35
36	Medical Director	Monthly	6,100	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	632	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	15	120	L10A, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	697	L11, C3	44
45	Social Service Consultant	13	697	L12, C3	45
46	Other(specify) Office Consultant	Monthly	541	L21, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	143	\$ 13,922		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, 2004**

Schedule 20A

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

Title	Hours Worked	Hours Paid	Amount	Ave. Hourly Wage
Care Plan Coordinator	1,932	2,052	28,215	13.75
Resident Service Director	2,040	2,160	18,201	8.43
	<u>3,972</u>	<u>4,212</u>	<u>46,416</u>	<u>11.02</u>

See Accountants' Compilation Report

Facility Name & ID Number Casey Care Center

0039800

Report Period Beginning: 07/01/03

Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Stephen Hopkins	Administrator	0	\$ 34,000	Workers' Compensation Insurance	\$ 61,413	IDPH License Fee	\$ 200	
Debbie Jackson	Administrator	0	11,277	Unemployment Compensation Insurance	15,104	Advertising: Employee Recruitment	2,054	
				FICA Taxes	85,939	Health Care Worker Background Check (Indicate # of checks performed <u>146</u>)	1,019	
				Employee Health Insurance	14,927	IHCA Dues	5,247	
				Employee Meals	16,659	Miscellaneous License & Fees	536	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	48	
				Other Employee Benefits	2,478	Expense Allocation	10	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 45,277			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Development Services of Illinois, Inc. - Administrative Service Fees			\$ 123,000					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 123,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 196,520	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,114	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Personnel Planners	U/C Consulting		\$ 1,620				Out-of-State Travel	\$
Campbell, Black, Carnine, Hedlin, Ballard, & McDonald	Legal		1,021	N/A			In-State Travel	2,115
							Seminar Expense	2,464
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 2,641	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,579

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Casey Care Center
Provider #: 0039800
07/01/03 to 06/30/04

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3) 2,641

Allocated from Caravilla Residential Centers, Inc:

Altschuler, Melvoin & Glasser LLP	Accounting	20,638
American Express Tax & Business Services	Accounting	451

Less: Nonallowable collection fees Cambell, Black, Carnine, Hedin, Ballard & McDonald (1,021)

Total (agree to Schedule V, line 19, column 8) 22,709

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
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4							N/A					
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Care Center# 0039800Report Period Beginning: 07/01/03Ending: 06/30/04**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 - \$5,247
- (3) Did the nursing home make political contributions or payments to a political 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? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,396 Line 10
- (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 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 benefit: on Schedule V. \$ 16,659 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? 54%
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? 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?
Firm Name: Altschuler, Melvoin, & 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? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

SEE ACCOUNTANTS' COMPILATION REPORT

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	95,652	7,757	5,135	108,544	0	108,544	0	108,544
2. Food Purchase	0	102,238	0	102,238	0	102,238	-16,659	85,579
3. Housekeeping	79,348	12,172	0	91,520	0	91,520	0	91,520
4. Laundry	35,301	13,584	0	48,885	0	48,885	0	48,885
5. Heat and Other Utilities	0	0	56,114	56,114	0	56,114	0	56,114
6. Maintenance	16,151	0	31,841	47,992	0	47,992	0	47,992
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	226,452	135,751	93,090	455,293	0	455,293	-16,659	438,634
9. Medical Director	0	0	6,100	6,100	0	6,100	0	6,100
10. Nursing & Medical Records	806,071	32,249	632	838,952	0	838,952	0	838,952
10a. Therapy	0	0	120	120	0	120	0	120
11. Activities	20,351	4,735	2,297	27,383	0	27,383	0	27,383
12. Social Services	17,330	22	697	18,049	0	18,049	0	18,049
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	1,003	1,003	0	1,003	0	1,003
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	843,752	37,006	10,849	891,607	0	891,607	0	891,607
17. Administrative	45,277	0	123,000	168,277	0	168,277	0	168,277
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	2,641	2,641	0	2,641	20,068	22,709
20. Fees, Subscriptions & Promotion	0	0	8,920	8,920	0	8,920	194	9,114
21. Clerical & General Office	20,884	4,164	21,449	46,497	0	46,497	2,226	48,723
22. Employee Benefits & Payroll	0	0	116,572	116,572	0	116,572	79,948	196,520
23. Inservice Training & Education	0	0	102	102	0	102	0	102
24. Travel and Seminar	0	0	4,385	4,385	0	4,385	194	4,579
25. Other Admin. Staff Trans	0	0	850	850	0	850	0	850
26. Insurance-Prop.Liab.Malpractice	0	0	-1	-1	0	-1	68,264	68,263
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	66,161	4,164	277,918	348,243	0	348,243	170,894	519,137
29. Total General Administrative	1,136,365	176,921	381,857	1,695,143	0	1,695,143	154,235	1,849,378
30. Depreciation	0	0	9,585	9,585	0	9,585	122,558	132,143
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	1,088	1,088	0	1,088	279,913	281,001
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	424,902	424,902	0	424,902	-424,902	0
35. Rent - Equipment & Vehicles	0	0	1,481	1,481	0	1,481	0	1,481
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	437,056	437,056	0	437,056	-22,431	414,625
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	58,194	58,194	0	58,194	0	58,194
43. Other (specify):*	0	0	12,185	12,185	0	12,185	-12,185	0
44. Total Special Cost Ce	0	0	70,379	70,379	0	70,379	-12,185	58,194
45. Grand Total	1,136,365	176,921	889,292	2,202,578	0	2,202,578	119,619	2,322,197

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	53,372	53,372
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	113,761	113,761
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	28,465	28,465
7. Other Prepaid Expenses	193	193
8. Accounts Receivable-Owner/Related Party	293,000	293,000
9. Other (specify):	7,642	7,642
10. Total current assets	496,433	496,433
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	110,000
14. Buildings, at Historical Cost	0	2,032,485
15. Leasehold Improvements, Historical Cost	15,921	473,459
16. Equipment, at Historical Cost	70,961	512,482
17. Accumulated Depreciation (book methods)	-43,031	-1,102,198
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	2,485	2,485
24. Total Long-Term Assets	46,336	2,028,713
25. Total Assets	542,769	2,525,146
CURRENT LIABILITIES		
26. Accounts Payable	266,624	266,624
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	67,675	67,675
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,483,424	978,562
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	2,817,723	1,312,861
LONG TERM LIABILITES		
39. Long-Term Notes Payable	6,380	3,242,811
40. Mortgage Payable	0	0
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	6,380	3,242,811
46. Total Liabilities	2,824,103	4,555,672
47. Total Equity	-2,281,334	-2,030,526
48. Total Liabilities and Equity	542,769	2,525,146

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,806,345
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,806,345
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,308
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	1,787
22. Laundry	0
Subtotal - Other Operating Revenue	4,095
24. Contributions	0
25. Interest and Other Investments Income	285
Subtotal - Non-Operating Revenue	285
27. Other Revenue (specify):	0
28. Other Revenue (specify):	1,868
Subtotal - Other Revenue	1,868
30. Total Revenue	1,812,593
31. General Services	455,293
32. Health Care	891,607
33. General Administration	348,243
34. Ownership	437,056
35. Special Cost Centers	12,185
35. Provider Participation Fee	58,194
37. Other	0
40. Total Expenses	2,202,578
41. Income Before Income Taxes	-389,985
42. Income Taxes	0
43. Net Income or Loss for the Year	-389,985

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