

		FOR OHF USE				

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**2005**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2005)**

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><b>I. IDPH Facility ID Number:</b> <u>0046714</u></p> <p><b>Facility Name:</b> <u>Casey Health Care Center</u></p> <p><b>Address:</b> <u>100 N. E. 15th</u> <u>Casey</u> <u>62420</u>        Number City Zip Code</p> <p><b>County:</b> <u>Clark</u></p> <p><b>Telephone Number:</b> <u>(217) 932-5217</u> Fax # <u>(217) 932-5408</u></p> <p><b>IDPA ID Number:</b> <u>743055934007</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>10/18/2004</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input 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><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" 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><b>In the event there are further questions about this report, please contact</b>  <b>Name:</b> <u>Christine Hanove</u> Telephone Number: <u>(312) 634-4581</u>  <b>Please send copies of desk review and audit adjustments to address on this page</b></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/05</u> to <u>12/31/05</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" style="width:100%"> <tr> <td style="width:20%">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td rowspan="2">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) _____ (Firm Name &amp; Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 384-6000</u> Fax # <u>(312) 634-5518</u></td> </tr> </table> <p align="center"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	(Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</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 Health Care Center

# 0046714 Report Period Beginning: 01/01/05 Ending: 12/31/05

**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	69	Intermediate (ICF)	69	25,185	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	25,185	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 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF					8
9	SNF/PED					9
10	ICF	15,045	6,738		21,783	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,045	6,738		21,783	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.49%

D. How many bed-hold days during this year were paid by the Department? None (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)

Meals on Wheels

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 07/01/04

J. Was the facility purchased or leased after January 1, 1978?  
 YES  Date 10/18/04 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: 12/31/05 Fiscal Year: 12/31/05

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

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Casey Health Care Center # 0046714 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	84,723	10,536		95,259	95,259	2,620	97,879		1	
2	Food Purchase		92,493		92,493	92,493	(1,599)	90,894		2	
3	Housekeeping	88,336	15,106		103,442	103,442	61	103,503		3	
4	Laundry		8,603		8,603	8,603	5	8,608		4	
5	Heat and Other Utilities			78,564	78,564	78,564	432	78,996		5	
6	Maintenance	25,979	21,445	5,861	53,285	53,285	4,168	57,453		6	
7	Other (specify):* Home Ofc. Benefits						891	891		7	
8	<b>TOTAL General Services</b>	199,038	148,183	84,425	431,646	431,646	6,578	438,224		8	
<b>B. Health Care and Programs</b>											
9	Medical Director			2,285	2,285	2,285		2,285		9	
10	Nursing and Medical Records	724,356	28,594	2,700	755,650	755,650	15,925	771,575		10	
10a	Therapy		250		250	250	3	253		10a	
11	Activities	21,070	401	1,227	22,698	22,698	8	22,706		11	
12	Social Services	24,046	618		24,664	24,664		24,664		12	
13	CNA Training									13	
14	Program Transportation									14	
15	Other (specify):* Home Ofc. Benefits						3,361	3,361		15	
16	<b>TOTAL Health Care and Programs</b>	769,472	29,863	6,212	805,547	805,547	19,297	824,844		16	
<b>C. General Administration</b>											
17	Administrative	45,168		106,500	151,668	151,668	(87,943)	63,725		17	
18	Directors Fees									18	
19	Professional Services			3,191	3,191	3,191	9,937	13,128		19	
20	Dues, Fees, Subscriptions & Promotion			1,695	1,695	1,695	2,741	4,436		20	
21	Clerical & General Office Expense	22,784	6,577	8,968	38,329	38,329	54,590	92,919		21	
22	Employee Benefits & Payroll Tax			183,456	183,456	183,456	1,580	185,036		22	
23	Inservice Training & Education			1,150	1,150	1,150	791	1,941		23	
24	Travel and Semina			810	810	810	763	1,573		24	
25	Other Admin. Staff Transportatior			6,734	6,734	6,734	3,393	10,127		25	
26	Insurance-Prop.Liab.Malpractice			27,649	27,649	27,649	1,748	29,397		26	
27	Other (specify):* Home Ofc. Benefits						12,211	12,211		27	
28	<b>TOTAL General Administration</b>	67,952	6,577	340,153	414,682	414,682	(189)	414,493		28	
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,036,462	184,623	430,790	1,651,875	1,651,875	25,686	1,677,561		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 &amp; ID Number Casey Health Care Center

#0046714

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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			63,587	63,587		63,587	(7,827)	55,760			30
31	Amortization of Pre-Op. & Org											31
32	Interest			81,676	81,676		81,676	12,589	94,265			32
33	Real Estate Taxes			19,760	19,760		19,760	21	19,781			33
34	Rent-Facility & Grounds							430	430			34
35	Rent-Equipment & Vehicle:			2,514	2,514		2,514	105	2,619			35
36	Other (specify): <sup>3</sup>											36
37	<b>TOTAL Ownership</b>			167,537	167,537		167,537	5,318	172,855			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:		1,283		1,283		1,283		1,283			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			37,778	37,778		37,778		37,778			42
43	Other (specify): <sup>3</sup> Nonallowable Cost			18,768	18,768		18,768	(18,768)				43
44	<b>TOTAL Special Cost Centers</b>		1,283	56,546	57,829		57,829	(18,768)	39,061			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,036,462	185,906	654,873	1,877,241		1,877,241	12,236	1,889,477			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 Program				3
4	Non-Patient Meals	(112)	2		4
5	Telephone, TV & Radio in Resident Room	(720)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,902)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(767)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(800)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(4,144)	43		24
25	Fund Raising, Advertising and Promotions	(11,168)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(1,319)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (36,932)		\$	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)	49,168		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 49,168		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 12,236		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 Shop		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>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Health Care Center  
Provider #: 0046714  
1/1/2005 to 12/31/2005

Schedule 5A

VI. Adjustment Detail  
Line 29 - Other

<u>Non-allowable expenses</u>	<u>Amount</u>	<u>Reference</u>
X-Ray Services	(330)	43
Lab Services	(152)	43
Service Charges - Vendor	(11)	43
Other	540	43
Chamber of Commerce	(150)	20
Special Events - Promotion	<u>(1,216)</u>	43
<b>Total</b>	<u><u>(1,319)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Health Care Center

ID# 0046714

Report Period Beginning: 01/01/05

Ending: 12/31/05

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Misc. - Part A	\$ (330)	43	1
2	Labs - Part A	(152)	43	2
3	Vendor service charges	(11)	43	3
4	Other	540	43	4
5	Disallowed Non-Care Related Real Estate Tax			5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	47		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Casey Health Care Center

# 0046714

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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)	
<b>1</b>	<b>A. General Services</b>													
1	Dietary	0	2,620	0	0	0	0	0	0	0	0	0	2,620	1
2	Food Purchase	(112)	83	0	10	0	0	0	0	0	0	0	(19)	2
3	Housekeeping	0	59	0	2	0	0	0	0	0	0	0	61	3
4	Laundry	0	5	0	0	0	0	0	0	0	0	0	5	4
5	Heat and Other Utilities	0	399	0	33	0	0	0	0	0	0	0	432	5
6	Maintenance	0	3,436	0	732	0	0	0	0	0	0	0	4,168	6
7	Other (specify):*	0	748	0	143	0	0	0	0	0	0	0	891	7
8	<b>TOTAL General Services</b>	(112)	7,350	0	920	0	0	0	0	0	0	0	8,158	8
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	4,333	0	11,592	0	0	0	0	0	0	0	15,925	10
10a	Therapy	0	3	0	0	0	0	0	0	0	0	0	3	10a
11	Activities	0	0	0	8	0	0	0	0	0	0	0	8	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	600	0	2,761	0	0	0	0	0	0	0	3,361	15
16	<b>TOTAL Health Care and Programs</b>	0	4,936	0	14,361	0	0	0	0	0	0	0	19,297	16
	<b>C. General Administration</b>													
17	Administrative	0	(87,943)	0	0	0	0	0	0	0	0	0	(87,943)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,388	0	4,549	0	0	0	0	0	0	0	9,937	19
20	Fees, Subscriptions & Promotions	0	2,453	0	438	0	0	0	0	0	0	0	2,891	20
21	Clerical & General Office Expenses	0	0	23,945	30,645	0	0	0	0	0	0	0	54,590	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	389	402	0	0	0	0	0	0	0	791	23
24	Travel and Seminar	0	0	533	230	0	0	0	0	0	0	0	763	24
25	Other Admin. Staff Transportation	0	0	1,941	1,452	0	0	0	0	0	0	0	3,393	25
26	Insurance-Prop.Liab.Malpractice	0	0	708	1,040	0	0	0	0	0	0	0	1,748	26
27	Other (specify):*	0	0	5,327	6,884	0	0	0	0	0	0	0	12,211	27
28	<b>TOTAL General Administration</b>	0	(80,102)	32,843	45,640	0	0	0	0	0	0	0	(1,619)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(112)	(67,816)	32,843	60,921	0	0	0	0	0	0	0	25,836	29



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
Mark Petersen	100	See attached Schedule 6A		See Attached Schedule 6A		

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	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,620	\$ 2,620	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	83	83	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	59	59	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	5	5	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	399	399	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,436	3,436	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	748	748	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,333	4,333	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	3	3	9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	600	600	10	
11	V	17 Administrative	106,500	Petersen Health Care, Inc.	100.00%	18,557	(87,943)	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,388	5,388	12	
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	2,453	2,453	13	
14	Total		\$ 106,500			\$ 38,684	\$ *	(67,816)	14

\* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Casey Health Care Center

# 0046714

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 23,945	\$ 23,945
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	389	389
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	533	533
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	1,941	1,941
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	708	708
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,327	5,327
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,411	3,411
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,589	4,589
23	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	430	430
24	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	105	105
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		\$			\$ 41,378	\$ * 41,378

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Health Care Center

# 0046714

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	2 Food	\$	Petersen Health Care II, Inc.	0.00%	\$ 10	\$ 10
16	V	3 Housekeeping		Petersen Health Care II, Inc.	0.00%	2	2
17	V	5 Utilities		Petersen Health Care II, Inc.	0.00%	33	33
18	V	6 Maintenance		Petersen Health Care II, Inc.	0.00%	732	732
19	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	143	143
20	V	10 Nursing & Medical Records		Petersen Health Care II, Inc.	0.00%	11,592	11,592
21	V	11 Activities		Petersen Health Care II, Inc.	0.00%	8	8
22	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	2,761	2,761
23	V	19 Professional Services		Petersen Health Care II, Inc.	0.00%	4,549	4,549
24	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	0.00%	438	438
25	V	21 Clerical & General Office		Petersen Health Care II, Inc.	0.00%	30,645	30,645
26	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	0.00%	402	402
27	V	24 Travel and Seminar		Petersen Health Care II, Inc.	0.00%	230	230
28	V	25 Other Admin. Staff Transport		Petersen Health Care II, Inc.	0.00%	1,452	1,452
29	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care II, Inc.	0.00%	1,040	1,040
30	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	6,884	6,884
31	V	30 Depreciation		Petersen Health Care II, Inc.	0.00%	6,664	6,664
32	V	32 Interest		Petersen Health Care II, Inc.	0.00%	8,000	8,000
33	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	0.00%	21	21
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 75,606	\$ * 75,606

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

SEE ACCOUNTANTS' COMPILATION REPORT

Casey Health Care Center  
0046714  
12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silvis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Center	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watska Rehabilitation & Health Care Center	Watska, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
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Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Casey Health Care Center      #      0046714      Report Period Beginning:      01/01/05      Ending:      12/31/05

## 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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	2	3.00	Salary	\$ 18,557	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 18,557		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 Health Care Center # 0046714 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 Petersen Health Care, Inc.  
 Street Address 830 West Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 691-8113  
 Fax Number ( 309) 691-8622

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	Dietary	Patient Days	46	\$ 82,166	\$ 81,693	21,783	\$ 2,620	1
2	2	Food	Patient Days	46	2,606		21,783	83	2
3	3	Housekeeping	Patient Days	46	1,857		21,783	59	3
4	4	Laundry	Patient Days	46	144		21,783	5	4
5	5	Utilities	Patient Days	46	12,513		21,783	399	5
6	6	Maintenance	Patient Days	46	107,775	81,080	21,783	3,436	6
7	7	Mgmt. Allocation of Benefits	Patient Days	46	23,459		21,783	748	7
8	10	Nursing and Medical Records	Patient Days	46	135,903	130,651	21,783	4,333	8
9	10A	Therapy	Patient Days	46	88		21,783	3	9
10	15	Mgmt. Allocation of Benefits	Patient Days	46	18,830		21,783	600	10
11	17	Administrative	Patient Days	46	582,000	582,000	21,783	18,557	11
12	19	Professional Services	Patient Days	46	168,984		21,783	5,388	12
13	20	Dues, Fees, Subs & Promos	Patient Days	46	76,921		21,783	2,453	13
14	21	Clerical & General Office	Patient Days	46	750,958	577,218	21,783	23,945	14
15	23	Inservice Training & Education	Patient Days	46	12,208		21,783	389	15
16	24	Travel & Seminar	Patient Days	46	16,731		21,783	533	16
17	25	Other Admin. Staff Transport	Patient Days	46	60,875		21,783	1,941	17
18	26	Insurance-Prop.Liab.Malp.	Patient Days	46	22,218		21,783	708	18
19	27	Mgmt. Allocation of Benefits	Patient Days	46	167,067		21,783	5,327	19
20	30	Depreciation	Patient Days	46	106,965		21,783	3,411	20
21	32	Interest	Patient Days	46	143,934		21,783	4,589	21
22	34	Rent - Facility & Grounds	Patient Days	46	13,500		21,783	430	22
23	35	Rent - Equipment & Vehicles	Patient Days	46	3,305		21,783	105	23
24									24
25	TOTALS				\$ 2,511,007	\$ 1,452,642		\$ 80,062	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Health Care Center # 0046714 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 Petersen Health Care II, Inc.  
 Street Address 830 West Trailcreek Drive  
 City / State / Zip Code Peoria, IL 61614  
 Phone Number ( 309) 691-8113  
 Fax Number ( 309) 691-8622

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	2	Food	Patient Days	241,523	7	\$ 114	\$ 21,783	\$ 10	1	
2	3	Housekeeping	Patient Days	241,523	7	24	21,783	2	2	
3	5	Utilities	Patient Days	241,523	7	370	21,783	33	3	
4	6	Maintenance	Patient Days	241,523	7	8,117	6,500	21,783	732	4
5	7	Mgmt. Allocation of Benefits	Patient Days	241,523	7	1,587	21,783	143	5	
6	10	Nursing & Medical Records	Patient Days	241,523	7	128,534	125,373	21,783	11,592	6
7	11	Activities	Patient Days	241,523	7	93	21,783	8	7	
8	15	Mgmt. Allocation of Benefits	Patient Days	241,523	7	30,610	21,783	2,761	8	
9	19	Professional Services	Patient Days	241,523	7	50,439	21,783	4,549	9	
10	20	Dues, Fees, Subs & Promotions	Patient Days	241,523	7	4,852	21,783	438	10	
11	21	Clerical & General Office	Patient Days	241,523	7	339,781	312,613	21,783	30,645	11
12	23	Inservice Training & Education	Patient Days	241,523	7	4,454	21,783	402	12	
13	24	Travel & Seminar	Patient Days	241,523	7	2,551	21,783	230	13	
14	25	Other Admin. Staff Transport	Patient Days	241,523	7	16,098	21,783	1,452	14	
15	26	Insurance-Prop.Liab.Malp.	Patient Days	241,523	7	11,534	21,783	1,040	15	
16	27	Mgmt. Allocation of Benefits	Patient Days	241,523	7	76,326	21,783	6,884	16	
17	30	Depreciation	Patient Days	241,523	7	73,886	21,783	6,664	17	
18	32	Interest	Patient Days	241,523	7	88,696	21,783	8,000	18	
19	33	Real Estate Taxes	Patient Days	241,523	7	236	21,783	21	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 838,302	\$ 444,486		\$ 75,606	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Health Care Center# 0046714

Report Period Beginning:

01/01/05

Ending:

12/31/05

## 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	U.S. Bank		X	Mortgage	Varies	1/4/2005	\$ 1,180,000	\$ 1,154,343	2/18/2011	0.0699	\$ 81,411	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 1,180,000	\$ 1,154,343			\$ 81,411	9
	<b>B. Non-Facility Related*</b>											
10									Amortization of Bond Fees		265	10
11									Home Office Allocation		12,589	11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 12,854	14
15	TOTALS (line 9+line14)						\$ 1,180,000	\$ 1,154,343			\$ 94,265	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None 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><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 17,318	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.)	2004	\$ 18,151	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 833	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 18,927	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>		\$	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. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax ap.</b> Allocation from Home Office		\$ 21	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		\$ 19,781	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	17,123	8
	2001	17,304	9
	2002	12,571	10
	2003	17,454	11
	2004	18,151	12
<b>Real estate tax accrual based 100% on prior year tax bill.</b>			
<b>FOR OHF USE ONLY</b>			
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	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 filec**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 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 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 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, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Casey Health Care Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0046714

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(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>03-11-17-20-403-005</u>	<u>S16 T10 R14 PT SE SE</u>	\$ <u>18,151.00</u>	\$ <u>18,151.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>18,151.00</u>	\$ <u>18,151.00</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Health Care Center

# 0046714 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,200 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity?  (a) Own the Facility  (b) Rent from a Related Organization  (c) Rent from Completely Unrelated Organization.

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

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

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

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

None

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	225,000	2004	\$ 35,000	1
2					2
3	TOTALS			\$ 35,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Casey Health Care Center

# 0046714

Report Period Beginning:

01/01/05

Ending:

12/31/05

**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	69	2004	1972	\$ 900,000	\$ 36,109	35	\$ 25,714	\$ (10,395)	\$ 32,143	4
5		Allocated from Home Office								5
6		2005		21,707			407	407	407	6
7										7
8										8
<b>Improvement Type**</b>										
9	Sidewalks		2004	4,990	332	15	332		359	9
10	Sidewalks		2005	4,885	163	15	163		163	10
11	Carpentry		2005	7,356	450	30	225	(225)	225	11
12	Alarm System		2005	13,492	282	10	450	168	450	12
13										13
14										14
15										15
16										16
17										17
18	2005 Allocation from Home Office Land Improvements		2005	1,255			39	39	39	18
19	2005 Allocation from Home Office Building Improvements		2005	35			2	2	2	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

\*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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 953,720	\$ 37,336		\$ 27,332	\$ (10,004)	\$ 33,788	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Casey Health Care Center

# 0046714

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$ 178,922	\$ 26,165	\$ 18,715	\$ (7,450)	5-10	\$ 23,650	71
72	Current Year Purchases	1,875	86	86		10	86	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office			9,627	9,627			74
75	TOTALS	\$ 180,797	\$ 26,251	\$ 28,428	\$ 2,177		\$ 23,736	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	N/A			\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	1	2	
	Reference	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)	\$ 1,169,517	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,587	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 55,760	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,827)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 57,524	85

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

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

G. Construction-in-Progress

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

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

\*\* This must agree with Schedule V line 30, column 1

SEE ACCOUNTANTS' COMPILATION REPORT

**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			Home Office Allocation		430			5
6								6
7	TOTAL				\$ 430			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>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34. N/A  
 This amount was calculated by dividing the total amount to be amortized N/A  
 by the length of the lease 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: \$ 2,619 Description: Tile roller-14; Copier-2500; Allocated from Home Office \$105  
 (Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>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 CNA _____</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 CNA _____</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 Wage (c)				
6	Transportation				
7	Contractual Payment:				
8	CNA 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 benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs

C. CONTRACTUAL INCOME

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

\$ \_\_\_\_\_

D. NUMBER OF CNAs TRAINED

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

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

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	10(2),(7)	hrs				253		253	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen Supplies	39(2)					1,283		1,283	13
14	TOTAL			\$		\$	1,536		\$ 1,536	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 353,174	\$ 353,174	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>none</u> )	239,028	239,028	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,115	4,115	6
7	Other Prepaid Expenses	5,288	5,288	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	5,000	5,000	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 606,605</b>	<b>\$ 606,605</b>	<b>10</b>
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	44,875	35,000	13
14	Buildings, at Historical Cost	900,000	921,707	14
15	Leasehold Improvements, at Historical Cost	20,848	32,013	15
16	Equipment, at Historical Cost	180,797	180,797	16
17	Accumulated Depreciation (book methods)	(72,385)	(57,524)	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): <u>Loan Costs</u>	1,595	1,595	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,075,730</b>	<b>\$ 1,113,588</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 1,682,335</b>	<b>\$ 1,720,193</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 74,450	\$ 74,450	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,856	77,856	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,875	13,875	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,927	18,927	32
33	Accrued Interest Payable	6,743	6,743	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	<b>Other Current Liabilities(specify):</b>			36
37	<u>Other Accrued Expenses</u>	11,547	11,547	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 203,398</b>	<b>\$ 203,398</b>	<b>38</b>
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,154,343	1,154,343	40
41	Bonds Payable			41
42	Deferred Compensation			42
43	<b>Other Long-Term Liabilities(specify):</b>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 1,154,343</b>	<b>\$ 1,154,343</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,357,741</b>	<b>\$ 1,357,741</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 324,594</b>	<b>\$ 362,452</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 1,682,335</b>	<b>\$ 1,720,193</b>	<b>48</b>

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>58,609</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment</b>		<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>58,609</b>	<b>6</b>
<b>A. Additions (deductions):</b>			
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>265,985</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>265,985</b>	<b>17</b>
<b>B. Transfers (Itemize):</b>			
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>324,594</b>	<b>24</b> *

Operating Entity Only

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Casey Health Care Center

# 0046714

Report Period Beginning: 01/01/05

Ending:

12/31/05

**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 expenses.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,142,783	1
2	Discounts and Allowances for all Level		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,142,783	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 Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	112	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 112	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income**		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Misc income</b>	331	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 331	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,143,226	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	431,646	31
32	Health Care	805,547	32
33	General Administration	414,682	33
<b>B. Capital Expense</b>			
34	Ownership	167,537	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	20,051	35
36	Provider Participation Fee	37,778	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 1,877,241	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	265,985	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 265,985	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.  
This entity is a cash basis taxpayer.

\*\*\* 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 Health Care Center**

# 0046714

Report Period Beginning: 01/01/05

Ending:

12/31/05

**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	2,080	2,080	\$ 51,589	\$ 24.80	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,415	4,506	80,644	17.90	3
4	Licensed Practical Nurses	10,459	10,657	183,211	17.19	4
5	CNAs & Orderlies	36,937	38,300	374,231	9.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,150	2,150	18,714	8.70	9
10	Activity Assistants			2,356		10
11	Social Service Worker	2,009	2,081	24,046	11.56	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,040	21,982	10.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,538	8,802	62,741	7.13	15
16	Dishwashers					16
17	Maintenance Worker	1,989	2,045	25,979	12.70	17
18	Housekeepers	11,378	11,416	88,336	7.74	18
19	Laundry					19
20	Administrator	2,072	2,072	45,168	21.80	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,062	2,078	22,784	10.96	24
25	Vocational Instructor					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					31
32	Other Health Care (Care Plans)	2,051	2,059	34,681	16.84	32
33	Other(specify)					33
34	<b>TOTAL (lines 1 - 33)</b>	<b>88,180</b>	<b>90,286</b>	<b>\$ 1,036,462 *</b>	<b>\$ 11.48</b>	<b>34</b>

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	2 visits	2,285	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	9 visits	2,700	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	<b>TOTAL (lines 35 - 48)</b>		<b>\$ 4,985</b>		<b>49</b>

**C. CONTRACT NURSES**

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

SEE ACCOUNTANTS' COMPILATION REPORT



**Casey Health Care Center**

**Provider #: 0046714**

**01/01/05 to 12/31/05**

**Schedule 21A**

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	3,191
Allocated from Management Company - Legal	102
Allocated from Management Company - Other	9,835
Total (agree to Schedule V, line 19, column 8)	<u>13,128</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										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					7	8	9	10	11	12	13	14	15	16
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
2														
3														
4														
5	N/A													
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	<b>TOTALS</b>		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Casey Health Care Center

# 0046714

Report Period Beginning: 01/01/05

Ending: 12/31/05

## 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 No  
If YES, give association name and amount N/A
- (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? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 3,743 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 during this cost report period. \$ 37,778  
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 for an individual employee? No If YES, attach an explanation of the allocation
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services if 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. \$ 1,580 Has any meal income been offset against related costs? Yes Indicate the amount \$ 112
- (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 program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
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? N/A  
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: Ginoli & Co. 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 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

RECONCILIATION REPORT

10:26 AM 5/16/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	12,236	equal to	12,236	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	94,265	equal to	94,265	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	19,781	equal to	19,781	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	55,760	equal to	55,760	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	430	equal to	430	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,619	equal to	2,619	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages	0	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	253	equal to	250	3	FAILED	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	1,536	equal to	1,533	3	FAILED	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39.10a	2
Income Stat. General Serv.	431,646	equal to	431,646	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	805,547	equal to	805,547	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	414,682	equal to	414,682	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	167,537	equal to	167,537	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	20,051	equal to	20,051	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	37,778	equal to	37,778	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	689,675	equal to	724,356	-34,681	FAILED	OK Care Coord.	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	21,070	equal to	21,070	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	24,046	equal to	24,046	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	84,723	equal to	84,723	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	25,979	equal to	25,979	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	88,336	equal to	88,336	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to	0	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	45,168	equal to	45,168	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	22,784	equal to	22,784	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,036,462	equal to	1,036,462	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	0	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	2,285	< or = to	2,285	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,700	< or = to	2,700	0	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	1,227	-1,227	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched. - Admin. Salar.	45,168	equal to	45,168	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched. - Admin. Other	106,500	equal to	106,500	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched. - Prof. Serv.	3,191	equal to	3,191	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched. - Benefit/Taxes	185,036	equal to	185,036	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched. - Sched of dues...	4,436	equal to	4,436	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched. - Sched. of trav	1,573	equal to	1,573	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	37,778	equal to	37,778	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	1,580	< or = to	1,580	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	1,580	equal to	1,580	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	49,168	equal to	49,168	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	1,154,343	equal to	1,154,343	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	18,927	equal to	18,927	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	35,000	equal to	35,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	953,720	equal to	953,720	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	180,797	equal to	180,797	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	57,524	equal to	57,524	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	324,594	equal to	324,594	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	265,985	equal to	265,985	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..1	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,682,335	equal to	1,682,335	0	O.K.	Pg17 H41		25	1	Pg17 S41	N/A	48	1

Casey Health Care Center  
 IDHFS Comparative Data - Per Resident Day Cost  
 Year Ending 12/31/05

Enter your HSA # in next column ===== 4  
 Census (Pulls from Page 2) 21,783

Cost Report Line	Description	Your Facility	Average Median Cost Per Day (2003)	
			State	HSA
1	Dietary	4.49	6.01	6.48
2	Food Purchase	4.17	4.31	4.40
3	Housekeeping	4.75	3.70	3.68
4	Laundry	0.40	1.85	1.90
5	Heat & Other Utilities	3.63	2.95	2.93
6	Maintenance	2.64	3.01	3.03
8	Total General Services	20.12	22.58	22.99
10	Nursing & Medical Records	35.42	41.83	43.12
10A	Therapy	0.01	2.10	2.69
11	Activities	1.04	1.91	1.92
12	Social Services	1.13	1.42	1.64
16	Total Health Care & Programs	37.87	49.48	51.22
17	Administration	2.93	3.36	3.15
19	Professional Services	0.60	0.99	0.85
21	Clerical & Gen. Office Expense	4.27	4.79	4.97
22	Employee Benefits & PR Taxes	8.49	10.09	11.01
24	Travel & Seminar	0.07	0.08	0.13
26	Insurance-Property, Liability & Malpractice	1.35	2.58	2.55
28	Total General Administrative	19.03	24.94	26.11
29	Total Operating Expenses	77.01	98.06	100.03
30	Depreciation	2.56	3.70	4.08
32	Interest	4.33	2.54	1.96
33	Real Estate Taxes	0.91	1.38	1.08
37	Total Operating and Ownership Cost	84.95	109.17	109.83

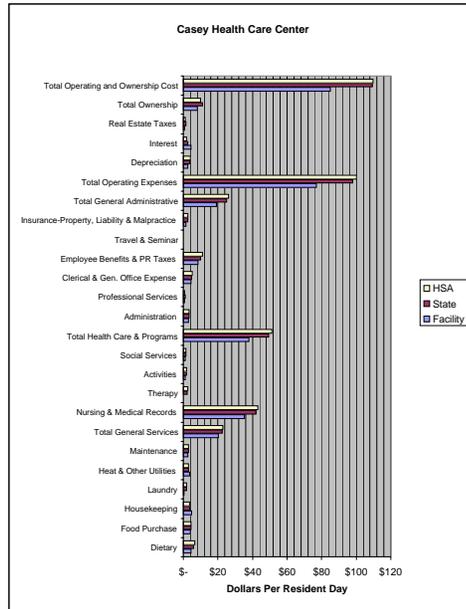
**Notes:**  
 Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.  
 The Average Median Cost Per Day for the State and your HSA is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.

IDHFS LTC Profiles

LTC Median Per Diem Cost by HSA - 2003 Cost Reports  
 2003 (Run June 1, 2004)

UN-INFLATED

Cost Report Line	Description	State-Wide	HSA											10th %	90th %
			1	2	3	4	5	6	7	8	9	10	11		
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	<b>TOTAL GENERAL SERVICES</b>	<b>22.58</b>	<b>24.49</b>	<b>22.99</b>	<b>21.14</b>	<b>22.99</b>	<b>21.47</b>	<b>22.65</b>	<b>22.65</b>	<b>22.65</b>	<b>22.45</b>	<b>24.49</b>	<b>21.73</b>	<b>17.57</b>	<b>31.51</b>
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	<b>TOTAL HEALTH CARE &amp; PROGRAMS</b>	<b>49.48</b>	<b>50.39</b>	<b>51.22</b>	<b>46.39</b>	<b>51.22</b>	<b>41.58</b>	<b>52.34</b>	<b>52.34</b>	<b>52.34</b>	<b>54.96</b>	<b>50.39</b>	<b>49.49</b>	<b>32.10</b>	<b>77.23</b>
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	<b>TOTAL GENERAL ADMINISTRATIVE</b>	<b>24.94</b>	<b>25.31</b>	<b>26.11</b>	<b>23.02</b>	<b>26.11</b>	<b>21.37</b>	<b>25.81</b>	<b>25.81</b>	<b>25.81</b>	<b>26.59</b>	<b>25.31</b>	<b>22.93</b>	<b>16.95</b>	<b>39.14</b>
29	<b>TOTAL OPERATING EXPENSES</b>	<b>98.06</b>	<b>100.77</b>	<b>100.03</b>	<b>92.47</b>	<b>100.03</b>	<b>88.05</b>	<b>100.96</b>	<b>100.96</b>	<b>100.96</b>	<b>103.01</b>	<b>100.77</b>	<b>94.71</b>	<b>69.40</b>	<b>142.56</b>
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	<b>TOTAL OWNERSHIP</b>	<b>11.11</b>	<b>9.73</b>	<b>9.80</b>	<b>8.00</b>	<b>9.80</b>	<b>7.04</b>	<b>14.54</b>	<b>14.54</b>	<b>14.54</b>	<b>11.02</b>	<b>9.73</b>	<b>8.39</b>	<b>3.76</b>	<b>23.58</b>
	<b>TOTAL OPERATING &amp; OWNERSHIP COST</b>	<b>109.17</b>	<b>110.50</b>	<b>109.83</b>	<b>100.47</b>	<b>109.83</b>	<b>95.09</b>	<b>115.50</b>	<b>115.50</b>	<b>115.50</b>	<b>114.03</b>	<b>110.50</b>	<b>103.10</b>	<b>73.16</b>	<b>166.14</b>



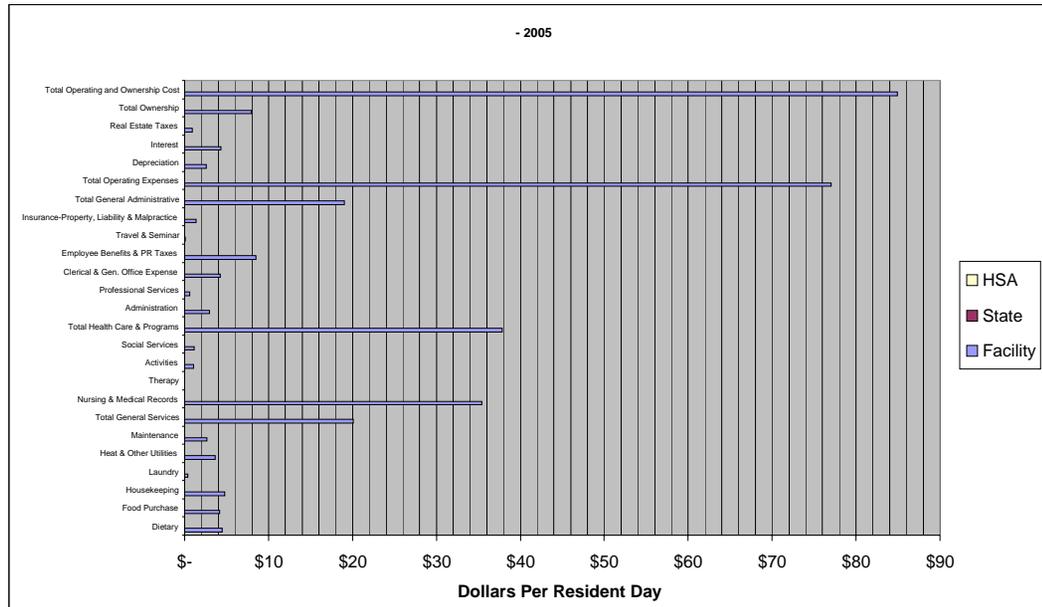
Casey Health Care Center  
 IDPA Comparative Data - Per Resident Day Cost  
 Year Ending 12/31/05

Enter your HSA # in next column 11  
 Census (Pulls from Page 2) 21,783

Cost Report Line	Description	2005			2004			2003			2002		
		Per Diem Your Facility	2004 Median Cost Per Day State	HSA	Per Diem Your Facility	2004 Median Cost Per Day State	HSA	Per Diem Your Facility	2003 Median Cost Per Day State	HSA	Per Diem Your Facility	2002 Median Cost Per Day State	HSA
1	Dietary	4.49	-	-	#DIV/0!	-	-	#DIV/0!	6.10	5.70	#DIV/0!	6.01	5.60
2	Food Purchase	4.17	-	-	#DIV/0!	-	-	#DIV/0!	4.31	4.11	#DIV/0!	4.27	4.09
3	Housekeeping	4.75	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.61	#DIV/0!	3.65	3.48
4	Laundry	0.40	-	-	#DIV/0!	-	-	#DIV/0!	1.85	2.13	#DIV/0!	1.90	2.23
5	Heat & Other Utilities	3.63	-	-	#DIV/0!	-	-	#DIV/0!	2.95	2.95	#DIV/0!	2.71	2.73
6	Maintenance	2.64	-	-	#DIV/0!	-	-	#DIV/0!	3.01	2.82	#DIV/0!	2.99	2.92
8	Total General Services	20.12	-	-	#DIV/0!	-	-	#DIV/0!	22.58	21.73	#DIV/0!	22.09	22.04
10	Nursing & Medical Records	35.42	-	-	#DIV/0!	-	-	#DIV/0!	41.83	42.15	#DIV/0!	40.68	41.16
10A	Therapy	0.01	-	-	#DIV/0!	-	-	#DIV/0!	2.10	2.24	#DIV/0!	1.85	2.27
11	Activities	1.04	-	-	#DIV/0!	-	-	#DIV/0!	1.91	1.54	#DIV/0!	1.88	1.60
12	Social Services	1.13	-	-	#DIV/0!	-	-	#DIV/0!	1.42	1.27	#DIV/0!	1.44	1.32
16	Total Health Care & Programs	37.87	-	-	#DIV/0!	-	-	#DIV/0!	49.48	49.49	#DIV/0!	47.55	47.76
17	Administration	2.93	-	-	#DIV/0!	-	-	#DIV/0!	3.36	3.17	#DIV/0!	3.39	3.54
19	Professional Services	0.60	-	-	#DIV/0!	-	-	#DIV/0!	0.99	0.77	#DIV/0!	0.98	0.72
21	Clerical & Gen. Office Expense	4.27	-	-	#DIV/0!	-	-	#DIV/0!	4.79	4.25	#DIV/0!	4.58	4.31
22	Employee Benefits & PR Taxes	8.49	-	-	#DIV/0!	-	-	#DIV/0!	10.09	9.08	#DIV/0!	9.63	8.44
24	Travel & Seminar	0.07	-	-	#DIV/0!	-	-	#DIV/0!	0.08	0.07	#DIV/0!	0.09	0.09
26	Insurance-Property, Liability & Malpractice	1.35	-	-	#DIV/0!	-	-	#DIV/0!	2.58	2.61	#DIV/0!	2.19	2.03
28	Total General Administrative	19.03	-	-	#DIV/0!	-	-	#DIV/0!	24.94	22.93	#DIV/0!	23.47	21.93
29	Total Operating Expenses	77.01	-	-	#DIV/0!	-	-	#DIV/0!	98.06	94.71	#DIV/0!	94.39	91.33
30	Depreciation	2.56	-	-	#DIV/0!	-	-	#DIV/0!	3.70	3.38	#DIV/0!	3.53	3.04
32	Interest	4.33	-	-	#DIV/0!	-	-	#DIV/0!	2.54	1.50	#DIV/0!	2.73	1.54
33	Real Estate Taxes	0.91	-	-	#DIV/0!	-	-	#DIV/0!	1.38	1.11	#DIV/0!	1.30	1.03
37	Total Ownership	7.94	-	-	#DIV/0!	-	-	#DIV/0!	11.11	8.39	#DIV/0!	11.44	10.00
	Total Operating and Ownership Cost	84.95	-	-	#DIV/0!	-	-	#DIV/0!	103.10	103.10	#DIV/0!	105.83	101.30

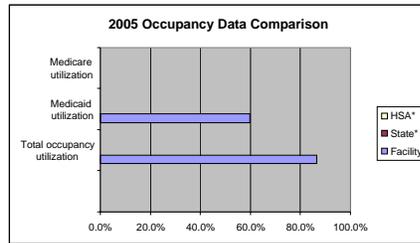
Notes:  
 Your Facility data is from page 3, column 8 of each of your respective Medicaid cost reports, divided by the respective annual census.

The 2005, 2004, 2003, & 2002 Median Cost Per Day for the State and your HSA is taken from data available from the Illinois Department of Public Aid and corresponds with the respective cost report data after final adjustments.



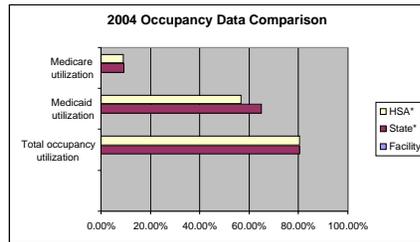
**2005**

Your Facility	State*	HSA*
Total occupancy utilization	86.49%	0.00%
Medicaid utilization	59.74%	0.00%
Medicare utilization	0.00%	0.00%
Private pay percent utilization	28.75%	N/A
Capacity in Patient Days	25,185	N/A
Census days of service provided	21,783	N/A



**2004**

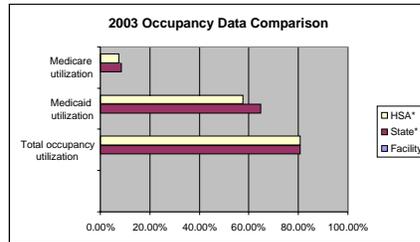
Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.50%
Medicaid utilization	#DIV/0!	65.00%
Medicare utilization	#DIV/0!	9.40%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A



\* State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

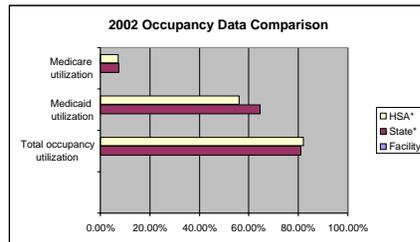
**2003**

Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.80%
Medicaid utilization	#DIV/0!	64.80%
Medicare utilization	#DIV/0!	8.50%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A



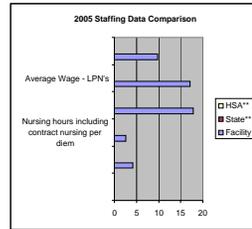
**2002**

Your Facility	State*	HSA*
Total occupancy utilization	#DIV/0!	80.90%
Medicaid utilization	#DIV/0!	64.50%
Medicare utilization	#DIV/0!	7.40%
Private pay percent utilization	#DIV/0!	N/A
Capacity in Patient Days	N/A	N/A
Census days of service provided	N/A	N/A



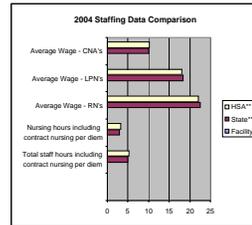
**2005**

Year	State**	HSA**
<b>Facility</b>		
Total staff hours including contract nursing per diem	4.14	0.00
Nursing hours including contract nursing per diem	2.55	0.00
Average Wage - RN's	17.9	0.00
Average Wage - LPN's	17.19	0.00
Average Wage - CNA's	9.77	0.00



**2004**

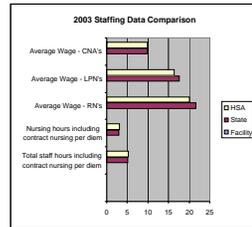
Year	State**	HSA**
<b>Facility</b>		
Total staff hours including contract nursing per diem	5.00	5.30
Nursing hours including contract nursing per diem	3.00	3.20
Average Wage - RN's	22.54	22.05
Average Wage - LPN's	18.40	18.02
Average Wage - CNA's	10.02	10.13



\*\* State and HSA data for 2004 and 2005 is not expected to be available from HFS until March 2006 and 2007 respectively.

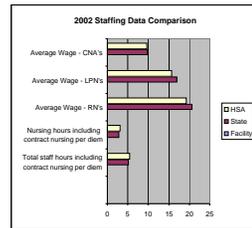
**2003**

Year	State	HSA
<b>Facility</b>		
Total staff hours including contract nursing per diem	5.10	5.30
Nursing hours including contract nursing per diem	2.90	3.10
Average Wage - RN's	21.56	19.99
Average Wage - LPN's	17.64	16.41
Average Wage - CNA's	9.91	9.89

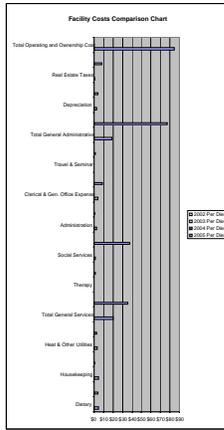


**2002**

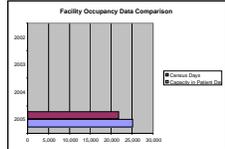
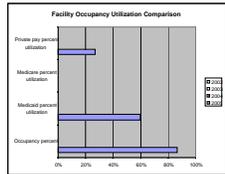
Year	State	HSA
<b>Facility</b>		
Total staff hours including contract nursing per diem	5.20	5.40
Nursing hours including contract nursing per diem	2.80	3.10
Average Wage - RN's	20.69	19.18
Average Wage - LPN's	16.89	15.72
Average Wage - CNA's	9.73	9.65



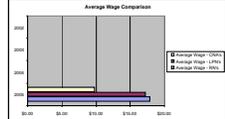
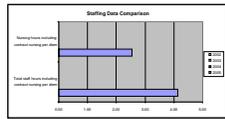
Report Line	Description	Year 2003	Year 2004	Year 2003	Year 2004
		Facility	Facility	Per Bed	Per Bed
1	Energy	4.81	450V/01	450V/01	450V/01
2	Food Purchase	4.17	450V/01	450V/01	450V/01
3	Housekeeping	4.75	450V/01	450V/01	450V/01
4	Laundry	4.40	450V/01	450V/01	450V/01
5	Heat & Other Utilities	3.43	450V/01	450V/01	450V/01
6	Maintenance	2.66	450V/01	450V/01	450V/01
8	Total General Services	28.32	450V/01	450V/01	450V/01
9	Nursing & Medical Records	35.42	450V/01	450V/01	450V/01
10A	Therapy	6.00	450V/01	450V/01	450V/01
11	Medication	1.66	450V/01	450V/01	450V/01
12	Social Services	1.13	450V/01	450V/01	450V/01
16	Total Health Care & Programs	77.67	450V/01	450V/01	450V/01
17	Administration	2.93	450V/01	450V/01	450V/01
19	Professional Services	6.40	450V/01	450V/01	450V/01
21	Child & Gen. Office Expense	4.27	450V/01	450V/01	450V/01
22	Medical Records & PR Taxes	4.40	450V/01	450V/01	450V/01
24	Travel & Lodging	6.07	450V/01	450V/01	450V/01
26	Insurance-Property, Liability & Malpractice	1.35	450V/01	450V/01	450V/01
28	Total General Administration	59.62	450V/01	450V/01	450V/01
29	Total Operating Expenses	27.60	450V/01	450V/01	450V/01
30	Depreciation	2.76	450V/01	450V/01	450V/01
32	Interest	4.33	450V/01	450V/01	450V/01
33	Total Facility Taxes	4.90	450V/01	450V/01	450V/01
37	Total Ownership	7.66	450V/01	450V/01	450V/01
	Total Operating and Ownership Cost	64.95	450V/01	450V/01	450V/01



	Facility 2003	Facility 2004	Facility 2005
Occupancy percent	86.40%	85%00	85%00
Medicare percent utilization	58.74%	65%00	65%00
Medicaid percent utilization	0.00%	65%00	65%00
Private pay percent utilization	29.37%	65%00	65%00
Capacity in Patient Days	25,165	0	0
Current Days	25,760	0	0



	Facility 2003	Facility 2004	Facility 2005
Total staff hours including contract temporary per bed	4.94	0.00	0.00
Working hours including contract temporary per bed	2.00	0.00	0.00
Average Wage - BNY	17.90	0.00	0.00
Average Wage - LPHS	17.10	0.00	0.00
Average Wage - CHS	9.77	0.00	0.00



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	84,723	10,536	0	95,259	0	95,259	2,620	97,879
2. Food Purchase	0	92,493	0	92,493	0	92,493	-1,599	90,894
3. Housekeeping	88,336	15,106	0	103,442	0	103,442	61	103,503
4. Laundry	0	8,603	0	8,603	0	8,603	5	8,608
5. Heat and Other Utilities	0	0	78,564	78,564	0	78,564	432	78,996
6. Maintenance	25,979	21,445	5,861	53,285	0	53,285	4,168	57,453
7. Other (specify)*	0	0	0	0	0	0	891	891
8. Total General Services	199,038	148,183	84,425	431,646	0	431,646	6,578	438,224
9. Medical Director	0	0	2,285	2,285	0	2,285	0	2,285
10. Nursing & Medical Records	724,356	28,594	2,700	755,650	0	755,650	15,925	771,575
10a. Therapy	0	250	0	250	0	250	3	253
11. Activities	21,070	401	1,227	22,698	0	22,698	8	22,706
12. Social Services	24,046	618	0	24,664	0	24,664	0	24,664
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	3,361	3,361
16. Total Health Care & Programs	769,472	29,863	6,212	805,547	0	805,547	19,297	824,844
17. Administrative	45,168	0	106,500	151,668	0	151,668	-87,943	63,725
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	3,191	3,191	0	3,191	9,937	13,128
20. Fees, Subscriptions & Promotion	0	0	1,695	1,695	0	1,695	2,741	4,436
21. Clerical & General Office	22,784	6,577	8,968	38,329	0	38,329	54,590	92,919
22. Employee Benefits & Payroll	0	0	183,456	183,456	0	183,456	1,580	185,036
23. Inservice Training & Education	0	0	1,150	1,150	0	1,150	791	1,941
24. Travel and Seminar	0	0	810	810	0	810	763	1,573
25. Other Admin. Staff Trans	0	0	6,734	6,734	0	6,734	3,393	10,127
26. Insurance-Prop.Liab.Malpractice	0	0	27,649	27,649	0	27,649	1,748	29,397
27. Other (specify)*	0	0	0	0	0	0	12,211	12,211
28. Total General Adminis	67,952	6,577	340,153	414,682	0	414,682	-189	414,493
29. Total General Administrative	1,036,462	184,623	430,790	1,651,875	0	1,651,875	25,686	1,677,561
30. Depreciation	0	0	63,587	63,587	0	63,587	-7,827	55,760
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	81,676	81,676	0	81,676	12,589	94,265
33. Real Estate	0	0	19,760	19,760	0	19,760	21	19,781
34. Rent - Facility & Grounds	0	0	0	0	0	0	430	430
35. Rent - Equipment & Vehicles	0	0	2,514	2,514	0	2,514	105	2,619
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	167,537	167,537	0	167,537	5,318	172,855
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	1,283	0	1,283	0	1,283	0	1,283
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	0	0	37,778	37,778	0	37,778	0	37,778
43. Other (specify):*	0	0	18,768	18,768	0	18,768	-18,768	0
44. Total Special Cost Ce	0	1,283	56,546	57,829	0	57,829	-18,768	39,061
45. Grand Total	1,036,462	185,906	654,873	1,877,241	0	1,877,241	12,236	1,889,477

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	353,174	353,174
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	239,028	239,028
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	4,115	4,115
7. Other Prepaid Expenses	5,288	5,288
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	5,000	5,000
10. Total current assets	606,605	606,605
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	44,875	35,000
14. Buildings, at Historical Cost	900,000	921,707
15. Leasehold Improvements, Historical Cost	20,848	32,013
16. Equipment, at Historical Cost	180,797	180,797
17. Accumulated Depreciation (book methods)	-72,385	-57,524
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):	1,595	1,595
24. Total Long-Term Assets	1,075,730	1,113,588
25. Total Assets	1,682,335	1,720,193
CURRENT LIABILITIES		
26. Accounts Payable	74,450	74,450
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	77,856	77,856
31. Accrued Taxes Payable	13,875	13,875
32. Accrued Real Estate Taxes	18,927	18,927
33. Accrued Interest Payable	6,743	6,743
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	11,547	11,547
38. Total Current Liabilities	203,398	203,398
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	1,154,343	1,154,343
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	1,154,343	1,154,343
46. Total Liabilities	1,357,741	1,357,741
47. Total Equity	324,594	362,452
48. Total Liabilities and Equity	1,682,335	1,720,193

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,142,783
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	2,142,783
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	112
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	0
22. Laundry	0
Subtotal - Other Operating Revenue	112
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	331
28. Other Revenue (specify):	0
Subtotal - Other Revenue	331
30. Total Revenue	2,143,226
31. General Services	431,646
32. Health Care	805,547
33. General Administration	414,682
34. Ownership	167,537
35. Special Cost Centers	20,051
35. Provider Participation Fee	37,778
37. Other	0
40. Total Expenses	1,877,241
41. Income Before Income Taxes	265,985
42. Income Taxes	0
43. Net Income or Loss for the Year	265,985

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IDPA LTC Profiles  
 LTC Median Per Diem Cost by HSA - 2004 Cost Reports  
 2004 (Run June 1, 2004)

UN-INFLATED

Casey  
 Health  
 Care  
 Center  
 2004  
 Costs

Casey  
 Health  
 Care  
 Center  
 2004  
 Census

Cost Report	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
1	Dietary												
2	Food Purchase												
3	Housekeeping												
4	Laundry												
5	Heat & Other Utilities												
6	Maintenance												
8	<b>TOTAL GENERAL SERVICES</b>												
10	Nursing & Medical Records												
10A	Therapy												
11	Activities												
12	Social Services												
16	<b>TOTAL HEALTH CARE &amp; PROGRAMS</b>												
17	Administration												
19	Professional Services												
21	Clerical & Gen. Office Expense												
22	Employee Benefits & PR Taxes												
24	Travel & Seminar												
26	Insurance-Property, liability & Malpractice												
28	<b>TOTAL GENERAL ADMINISTRATIVE</b>												
29	<b>TOTAL OPERATING EXPENSES</b>												
30	Depreciation												
32	Interest												
33	Real Estate Taxes												
37	<b>TOTAL OWNERSHIP</b>												
	<b>TOTAL OPERATING &amp; OWNERSHIP COST</b>												

10th % 90th %

Cost Report	Description
1	Dietary
2	Food Purchase
3	Housekeeping
4	Laundry
5	Heat & Other Utilities
6	Maintenance
8	<b>TOTAL GENERAL SERVICES</b>
10	Nursing & Medical Records
10A	Therapy
11	Activities
12	Social Services
16	<b>TOTAL HEALTH CARE &amp; PROGRAMS</b>
17	Administration
19	Professional Services
21	Clerical & Gen. Office Expense
22	Employee Benefits & PR Taxes
24	Travel & Seminar
26	Insurance-Property, liability & Malpractice
28	<b>TOTAL GENERAL ADMINISTRATIVE</b>
29	<b>TOTAL OPERATING EXPENSES</b>
30	Depreciation
32	Interest
33	Real Estate Taxes
37	<b>TOTAL OWNERSHIP</b>
	<b>TOTAL OPERATING &amp; OWNERSHIP COST</b>

Average Wage Data Table

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	
Total staff hours including contract nurses per diem	5.00	5.30	5.30	5.30	5.30	5.10	4.80	4.80	4.80	5.10	5.30	5.20
Nursing hours including contract nurses per diem	3.00	3.20	3.20	3.30	3.20	3.10	2.80	2.80	2.80	3.10	3.20	3.10
RN	22.54	22.05	20.73	19.72	20.73	17.47	25.72	25.72	25.72	23.44	22.05	20.42
LPN	18.4	18.02	17.23	15.4	17.23	13.82	21.06	21.06	21.06	19.09	18.02	17.13
CNA	10.02	10.13	10.03	9.32	10.03	8.4	10.52	10.52	10.52	10.53	10.13	9.84
DON	28.97	27.38	25.17	23.86	25.17	22.23	34.39	34.39	34.39	30.41	27.38	25.97
ADON	25.23	23.95	21.85	19.41	21.85	19.13	28.74	28.74	28.74	26.68	23.95	23.72

2003 - Staffing and Occupancy Data

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	
Average Occupancy	80.50%	80.70%	80.40%	78.10%	80.40%	74.40%	81.80%	81.80%	81.80%	82.90%	80.70%	78.20%
Medicaid Utilization	65.00%	57.00%	56.70%	58.50%	56.70%	61.80%	70.60%	70.60%	70.60%	64.50%	57.00%	60.60%
Medicare Utilization	9.40%	7.70%	8.90%	9.30%	8.90%	8.80%	9.90%	9.90%	9.90%	10.30%	7.70%	8.90%

IDPA LTC Profiles  
 LTC Median Per Diem Cost by HSA - 2003 Cost Reports  
 2003 (Run June 1, 2004)

UN-INFLATED

Casey Health Care Center  
 Case Health Care Center  
 2003 Costs  
 2003 Census

Cost Report Line	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	10th %	90th %
1	Dietary	6.10	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	3.36	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	1.92	5.12
8	<b>TOTAL GENERAL SERVICES</b>	<b>22.58</b>	<b>24.49</b>	<b>22.99</b>	<b>21.14</b>	<b>22.99</b>	<b>21.47</b>	<b>22.65</b>	<b>22.65</b>	<b>22.65</b>	<b>22.45</b>	<b>24.49</b>	<b>21.73</b>	<b>17.57</b>	<b>31.51</b>
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	0.58	3.00
16	<b>TOTAL HEALTH CARE &amp; PROGRAMS</b>	<b>49.48</b>	<b>50.39</b>	<b>51.22</b>	<b>46.39</b>	<b>51.22</b>	<b>41.58</b>	<b>52.34</b>	<b>52.34</b>	<b>52.34</b>	<b>54.96</b>	<b>50.39</b>	<b>49.49</b>	<b>32.10</b>	<b>77.23</b>
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	0.88	4.32
28	<b>TOTAL GENERAL ADMINISTRATIVE</b>	<b>24.94</b>	<b>25.31</b>	<b>26.11</b>	<b>23.02</b>	<b>26.11</b>	<b>21.37</b>	<b>25.81</b>	<b>25.81</b>	<b>25.81</b>	<b>26.59</b>	<b>25.31</b>	<b>22.93</b>	<b>16.95</b>	<b>39.14</b>
29	<b>TOTAL OPERATING EXPENSES</b>	<b>98.06</b>	<b>100.77</b>	<b>100.03</b>	<b>92.47</b>	<b>100.03</b>	<b>88.05</b>	<b>100.96</b>	<b>100.96</b>	<b>100.96</b>	<b>103.01</b>	<b>100.77</b>	<b>94.71</b>	<b>69.40</b>	<b>142.56</b>
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	4.85
37	<b>TOTAL OWNERSHIP</b>	<b>11.11</b>	<b>9.73</b>	<b>9.80</b>	<b>8.00</b>	<b>9.80</b>	<b>7.04</b>	<b>14.54</b>	<b>14.54</b>	<b>14.54</b>	<b>11.02</b>	<b>9.73</b>	<b>8.39</b>	<b>3.76</b>	<b>23.58</b>
	<b>TOTAL OPERATING &amp; OWNERSHIP COST</b>	<b>109.17</b>	<b>110.50</b>	<b>109.83</b>	<b>100.47</b>	<b>109.83</b>	<b>95.09</b>	<b>115.50</b>	<b>115.50</b>	<b>115.50</b>	<b>114.03</b>	<b>110.50</b>	<b>103.10</b>	<b>73.16</b>	<b>166.14</b>

Cost Report Line	Description	10th %	90th %
1	Dietary	4.13	9.81
2	Food Purchase	3.36	6.04
3	Housekeeping	2.48	5.80
4	Laundry	0.91	3.14
5	Heat & Other Utilities	2.05	4.25
6	Maintenance	1.92	5.12
8	<b>TOTAL GENERAL SERVICES</b>	<b>17.57</b>	<b>31.51</b>
10	Nursing & Medical Records	27.25	64.47
10A	Therapy	-	10.55
11	Activities	1.06	3.45
12	Social Services	0.58	3.00
16	<b>TOTAL HEALTH CARE &amp; PROGRAMS</b>	<b>32.10</b>	<b>77.23</b>
17	Administration	1.71	7.21
19	Professional Services	0.07	3.44
21	Clerical & Gen. Office Expense	2.49	10.78
22	Employee Benefits & PR Taxes	6.33	19.34
24	Travel & Seminar	-	0.43
26	Insurance-Property, liability & Malpractice	0.88	4.32
28	<b>TOTAL GENERAL ADMINISTRATIVE</b>	<b>16.95</b>	<b>39.14</b>
29	<b>TOTAL OPERATING EXPENSES</b>	<b>69.40</b>	<b>142.56</b>
30	Depreciation	-	11.53
32	Interest	-	4.85
33	Real Estate Taxes	3.76	23.58
37	<b>TOTAL OWNERSHIP</b>	<b>3.76</b>	<b>23.58</b>
	<b>TOTAL OPERATING &amp; OWNERSHIP COST</b>	<b>73.16</b>	<b>166.14</b>

Average Wage Data Table

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	
Total staff hours including contract nurses per diem	5.10	5.30	5.30	5.00	5.30	5.10	4.90	4.90	4.90	5.10	5.30	5.30
Nursing hours including contract nurses per diem	2.90	3.20	3.10	3.10	3.10	3.00	2.70	2.70	2.70	3.00	3.20	3.10
RN	21.56	21.14	19.99	18.79	19.99	16.66	24.55	24.55	24.55	22.85	21.14	20.33
LPN	17.64	17.65	16.41	14.79	16.41	13.36	20.23	20.23	20.23	18.67	17.65	16.45
CNA	9.91	10.11	9.89	9.19	9.89	8.28	10.44	10.44	10.44	10.54	10.11	9.76
DON	27.82	26.67	24.49	23.07	24.49	20.82	33.29	33.29	33.29	29.65	26.67	24.62
ADON	24.39	22.67	21.12	19.67	21.12	18.73	27.45	27.45	27.45	26.14	22.67	22.50

2003 - Staffing and Occupancy Data

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	
Average Occupancy	80.80%	80.80%	80.60%	79.90%	80.60%	75.20%	82.00%	82.00%	82.00%	81.60%	80.80%	77.30%
Medicaid Utilization	64.80%	56.40%	57.70%	59.60%	57.70%	62.80%	70.00%	70.00%	70.00%	64.30%	56.40%	59.30%
Medicare Utilization	8.50%	7.50%	7.50%	7.70%	7.50%	8.70%	9.10%	9.10%	9.10%	9.30%	7.50%	8.00%

IDPA LTC Profiles  
 LTC Median Per Diem Cost by HSA - 2002 Cost Reports  
 2002 (Run June 1, 2004)

UN-INFLATED

Cost Report	Description	State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
1	Dietary	6.01	7.28	6.51	5.36	6.51	5.48	5.92	5.92	5.83	7.28	5.60	
2	Food Purchase	4.27	4.52	4.40	4.15	4.40	3.99	4.31	4.31	4.11	4.52	4.09	
3	Housekeeping	3.65	3.84	3.56	3.05	3.56	3.25	4.13	4.13	3.89	3.84	3.48	
4	Laundry	1.90	2.15	2.01	1.72	2.01	2.09	1.67	1.67	1.58	2.15	2.23	
5	Heat & Other Utilities	2.71	2.84	2.76	2.75	2.76	2.54	2.67	2.67	2.72	2.84	2.73	
6	Maintenance	2.99	3.41	2.96	2.91	2.96	2.48	3.16	3.16	2.90	3.41	2.92	
<b>8</b>	<b>TOTAL GENERAL SERVICES</b>	<b>22.09</b>	<b>24.39</b>	<b>22.49</b>	<b>20.85</b>	<b>22.49</b>	<b>20.47</b>	<b>22.71</b>	<b>22.71</b>	<b>22.66</b>	<b>24.39</b>	<b>22.04</b>	
10	Nursing & Medical Records	40.68	42.79	42.10	37.44	42.10	33.35	43.96	43.96	43.84	42.79	41.16	
10A	Therapy	1.85	1.90	2.38	2.86	2.38	1.81	1.54	1.54	3.02	1.90	2.27	
11	Activities	1.88	2.12	1.89	1.50	1.89	1.37	2.23	2.23	2.10	2.12	1.60	
12	Social Services	1.44	1.46	1.50	1.08	1.50	1.13	1.61	1.61	1.32	1.46	1.32	
<b>16</b>	<b>TOTAL HEALTH CARE &amp; PROGRAMS</b>	<b>47.55</b>	<b>50.19</b>	<b>49.32</b>	<b>44.36</b>	<b>49.32</b>	<b>39.56</b>	<b>50.57</b>	<b>50.57</b>	<b>52.75</b>	<b>50.19</b>	<b>47.76</b>	
17	Administration	3.39	3.49	3.30	3.27	3.30	3.61	3.39	3.39	3.20	3.49	3.54	
19	Professional Services	0.98	1.00	0.76	0.88	0.76	0.98	1.05	1.05	1.05	1.00	0.72	
21	Clerical & Gen. Office Expense	4.58	4.07	4.40	3.67	4.40	3.47	5.75	5.75	4.19	4.07	4.31	
22	Employee Benefits & PR Taxes	9.63	10.11	10.26	8.28	10.26	7.80	10.26	10.26	9.30	10.11	8.44	
24	Travel & Seminar	0.09	0.12	0.10	0.09	0.10	0.16	0.06	0.06	0.03	0.12	0.09	
26	Insurance-Property, liability & Malpractice	2.19	1.93	1.97	1.87	1.97	2.00	2.46	2.46	2.40	1.93	2.03	
<b>28</b>	<b>TOTAL GENERAL ADMINISTRATIVE</b>	<b>23.47</b>	<b>23.64</b>	<b>24.80</b>	<b>21.32</b>	<b>24.80</b>	<b>20.28</b>	<b>25.17</b>	<b>25.17</b>	<b>23.10</b>	<b>23.64</b>	<b>21.93</b>	
<b>29</b>	<b>TOTAL OPERATING EXPENSES</b>	<b>94.39</b>	<b>99.26</b>	<b>97.46</b>	<b>85.50</b>	<b>97.46</b>	<b>82.47</b>	<b>99.35</b>	<b>99.35</b>	<b>97.86</b>	<b>99.26</b>	<b>91.33</b>	
30	Depreciation	3.53	3.13	3.86	3.26	3.86	2.41	4.18	4.18	3.94	3.13	3.04	
32	Interest	2.73	2.84	2.05	2.60	2.05	1.55	4.55	4.55	2.14	2.84	1.54	
33	Real Estate Taxes	1.30	0.77	0.88	0.93	0.88	0.72	3.17	3.17	1.29	0.77	1.03	
<b>37</b>	<b>TOTAL OWNERSHIP</b>	<b>11.44</b>	<b>9.19</b>	<b>9.85</b>	<b>8.76</b>	<b>9.85</b>	<b>6.52</b>	<b>15.35</b>	<b>15.35</b>	<b>11.40</b>	<b>9.19</b>	<b>10.60</b>	
	<b>TOTAL OPERATING &amp; OWNERSHIP COST</b>	<b>105.83</b>	<b>108.45</b>	<b>107.31</b>	<b>94.26</b>	<b>107.31</b>	<b>88.99</b>	<b>114.70</b>	<b>114.70</b>	<b>109.26</b>	<b>108.45</b>	<b>101.30</b>	

10th %	90th %
4.17	9.77
3.29	5.90
2.51	5.63
1.10	3.13
1.89	4.03
1.95	5.11
<b>17.19</b>	<b>30.80</b>
26.11	62.04
-	10.03
1.13	3.39
0.58	3.00
<b>31.31</b>	<b>74.79</b>
1.65	6.84
0.07	2.93
2.36	10.72
6.22	17.51
-	0.37
0.83	3.92
<b>16.13</b>	<b>36.02</b>
<b>67.15</b>	<b>138.58</b>
0.73	8.09
-	12.86
-	5.05
<b>3.55</b>	<b>24.50</b>
<b>70.70</b>	<b>163.08</b>

Cost Report	Description	10th %	90th %
1	Dietary	3.29	5.90
2	Food Purchase	2.51	5.63
3	Housekeeping	1.10	3.13
4	Laundry	1.89	4.03
5	Heat & Other Utilities	1.95	5.11
6	Maintenance	26.11	62.04
<b>8</b>	<b>TOTAL GENERAL SERVICES</b>	<b>17.19</b>	<b>30.80</b>
10	Nursing & Medical Records	26.11	62.04
10A	Therapy	-	10.03
11	Activities	1.13	3.39
12	Social Services	0.58	3.00
<b>16</b>	<b>TOTAL HEALTH CARE &amp; PROGRAMS</b>	<b>31.31</b>	<b>74.79</b>
17	Administration	1.65	6.84
19	Professional Services	0.07	2.93
21	Clerical & Gen. Office Expense	2.36	10.72
22	Employee Benefits & PR Taxes	6.22	17.51
24	Travel & Seminar	-	0.37
26	Insurance-Property, liability & Malpractice	0.83	3.92
<b>28</b>	<b>TOTAL GENERAL ADMINISTRATIVE</b>	<b>16.13</b>	<b>36.02</b>
<b>29</b>	<b>TOTAL OPERATING EXPENSES</b>	<b>67.15</b>	<b>138.58</b>
30	Depreciation	0.73	8.09
32	Interest	-	12.86
33	Real Estate Taxes	-	5.05
<b>37</b>	<b>TOTAL OWNERSHIP</b>	<b>3.55</b>	<b>24.50</b>
	<b>TOTAL OPERATING &amp; OWNERSHIP COST</b>	<b>70.70</b>	<b>163.08</b>

2002 Census

2002 Costs

2002 - Average Wage Data Table

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11
Total staff hours including contract nursing per diem	5.20	5.50	5.40	5.00	5.40	5.10	5.00	5.00	4.90	5.50	5.30
Nursing hours including contract nurses per diem	2.80	3.10	3.10	3.00	3.10	2.90	2.60	2.60	2.60	3.10	3.00
RN	20.69	20.12	19.18	18.57	19.18	16.06	23.49	23.49	23.49	21.31	19.45
LPN	16.89	17.04	15.72	14.33	15.72	12.75	19.39	19.39	19.39	17.96	15.69
CNA	9.73	10.05	9.65	9.09	9.65	8.08	10.28	10.28	10.28	10.39	9.62
DON	26.38	24.75	22.98	22.48	22.98	20.02	31.78	31.78	31.78	28.56	23.68
ADON	23.27	21.44	20.51	18.93	20.51	17.26	26.34	26.34	26.34	24.33	21.27

2002 - Staffing and Occupancy Data

State-Wide	HSA 1	HSA 2	HSA 3	HSA 4	HSA 5	HSA 6	HSA 7	HSA 8	HSA 9	HSA 10	HSA 11	
Average Occupancy	80.90%	79.60%	81.90%	80.30%	81.90%	75.30%	82.20%	82.20%	82.00%	82.00%	79.60%	76.60%
Medicaid Utilization	64.50%	55.50%	56.10%	58.50%	56.10%	63.30%	69.90%	69.90%	69.90%	66.70%	55.50%	60.90%
Medicare Utilization	7.40%	6.80%	7.20%	6.10%	7.20%	7.40%	7.70%	7.70%	7.70%	8.20%	6.80%	7.00%