



Facility Name & ID Number Casey Health Care Center

# 0046714 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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 8/10/07

	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	69	Skilled (SNF)	69	25,254	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	69	TOTALS	69	25,254	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	13,408	6,211	1,452	21,071	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,408	6,211	1,452	21,071	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.44%

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 7/1/2004

J. Was the facility purchased or leased after January 1, 1978?

YES

Date 10/18/2004

NO

K. Was the facility certified for Medicare during the reporting year?

YES

NO

If YES, enter number of beds certified 69 and days of care provided 1,452

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES  NO

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Casey Health Care Center # 0046714 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

**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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	106,152	11,897		118,049		118,049	3,745	121,794		1
2	Food Purchase		128,902		128,902		128,902	(3,936)	124,966		2
3	Housekeeping	94,678	21,418		116,096		116,096	28	116,124		3
4	Laundry	8,102	9,414		17,516		17,516	2	17,518		4
5	Heat and Other Utilities			75,922	75,922		75,922	388	76,310		5
6	Maintenance	31,136	10,875	15,344	57,355		57,355	3,253	60,608		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							921	921		7
8	<b>TOTAL General Services</b>	<b>240,068</b>	<b>182,506</b>	<b>91,266</b>	<b>513,840</b>		<b>513,840</b>	<b>4,401</b>	<b>518,241</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,750	9,750		9,750		9,750		9
10	Nursing and Medical Records	760,328	51,148	6,146	817,622		817,622	5,297	822,919		10
10a	Therapy		167	192,579	192,746		192,746		192,746		10a
11	Activities	22,416	814	330	23,560		23,560		23,560		11
12	Social Services	12,083			12,083		12,083		12,083		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,135	1,135		15
16	<b>TOTAL Health Care and Programs</b>	<b>794,827</b>	<b>52,129</b>	<b>208,805</b>	<b>1,055,761</b>		<b>1,055,761</b>	<b>6,432</b>	<b>1,062,193</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	53,090		88,000	141,090		141,090	(58,844)	82,246		17
18	Directors Fees										18
19	Professional Services			5,607	5,607		5,607	7,674	13,281		19
20	Dues, Fees, Subscriptions & Promotions			3,585	3,585		3,585	2,422	6,007		20
21	Clerical & General Office Expenses	24,405	6,097	8,973	39,475		39,475	42,116	81,591		21
22	Employee Benefits & Payroll Taxes			145,713	145,713		145,713	733	146,446		22
23	Inservice Training & Education			212	212		212	222	434		23
24	Travel and Seminar							306	306		24
25	Other Admin. Staff Transportation			4,116	4,116		4,116	4,764	8,880		25
26	Insurance-Prop.Liab.Malpractice			13,563	13,563		13,563	1,319	14,882		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							10,416	10,416		27
28	<b>TOTAL General Administration</b>	<b>77,495</b>	<b>6,097</b>	<b>269,769</b>	<b>353,361</b>		<b>353,361</b>	<b>11,128</b>	<b>364,489</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>1,112,390</b>	<b>240,732</b>	<b>569,840</b>	<b>1,922,962</b>		<b>1,922,962</b>	<b>21,961</b>	<b>1,944,923</b>		<b>29</b>

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

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

Facility Name &amp; ID Number

Casey Health Care Center

#0046714

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			69,463	69,463		69,463	629	70,092			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			75,197	75,197		75,197	23,942	99,139			32
33	Real Estate Taxes			26,331	26,331		26,331	535	26,866			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,175	26,175		26,175	568	26,743			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			197,166	197,166		197,166	25,674	222,840			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		43,287		43,287		43,287		43,287			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,884	37,884		37,884		37,884			42
43	Other (specify):* Non-allowable Cost		899	43,099	43,998		43,998	(43,998)				43
44	<b>TOTAL Special Cost Centers</b>		44,186	80,983	125,169		125,169	(43,998)	81,171			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,112,390	284,918	847,989	2,245,297		2,245,297	3,637	2,248,934			45

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



Casey Health Care Center

ID# 0046714

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,456)	43	1
2	X-Rays-Part A	(729)	43	2
3	Disallowed Special Events	(83)	43	3
4	Resident Flowers	(470)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(129)	21	5
6	Offset Chamber of Commerce Dues	(150)	20	6
7	Offset Miscellaneous Nursing Supplies Revenue	(1,203)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(5,220)		49

Facility Name & ID Number

Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,745	\$ 3,745	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	61	61	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	28	28	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	388	388	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,289	2,289	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	921	921	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	6,500	6,500	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,135	1,135	10
11	V	17 Administrative	88,000	Petersen Health Care, Inc.	100.00%	29,156	(58,844)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,291	3,291	12
13	V							13
14	Total		\$ 88,000			\$ 47,516	\$ * (40,484)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,015	\$	1,015	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	36,588		36,588	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	222		222	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	223		223	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,881		2,881	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	175		175	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,416		10,416	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,986		3,986	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,804		2,804	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	535		535	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	456		456	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 59,301	\$ *	59,301	39

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

Facility Name &amp; ID Number

Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	964	964	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	4,383	4,383	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,557	1,557	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	5,657	5,657	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	733	733	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	83	83	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	1,883	1,883	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	1,144	1,144	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	15,048	15,048	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	21,197	21,197	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	112	112	38	
39	Total		\$			\$ 52,761	\$ *	52,761	39

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

Facility Name &amp; ID Number

Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

## 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	1,799,518	0.88	1.46	Salary	\$ 29,156	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	\$ 29,156		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Casey Health Care Center# 0046714 Report Period Beginning: 1/1/2008Ending: 2/31/2008

## 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 W. 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	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	21,071	\$ 3,745	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	21,071	61	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	21,071	28	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	21,071	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	21,071	388	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	21,071	2,289	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	21,071	921	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	21,071	6,500	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	21,071	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	21,071	1,135	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	21,071	29,156	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	21,071	3,291	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	21,071	1,015	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	21,071	36,588	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	21,071	222	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	21,071	223	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	21,071	2,881	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	21,071	175	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	21,071	10,416	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	21,071	3,986	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	21,071	2,804	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	21,071	535	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	21,071	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	21,071	456	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 106,817	25

Facility Name & ID Number Casey Health Care Center# 0046714 Report Period Beginning: 1/1/2008Ending: 2/31/2008

## 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 W. 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	Resident Days	331,413	13	\$	21,071	\$	1
2	2	Food	Resident Days	331,413	13		21,071		2
3	3	Housekeeping	Resident Days	331,413	13		21,071		3
4	4	Laundry	Resident Days	331,413	13		21,071		4
5	5	Utilities	Resident Days	331,413	13		21,071		5
6	6	Maintenance	Resident Days	331,413	13	15,163	21,071	964	6
7	7	Mgmt. Allocation of Benefits	Resident Days	331,413	13		21,071		7
8	10	Nursing and Medical Records	Resident Days	331,413	13		21,071		8
9	15	Mgmt. Allocation of Benefits	Resident Days	331,413	13		21,071		9
10	17	Administrative	Resident Days	331,413	13		21,071		10
11	19	Professional Services	Resident Days	331,413	13	68,939	21,071	4,383	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	331,413	13	24,482	21,071	1,557	12
13	21	Clerical and General Office	Resident Days	331,413	13	88,982	21,071	5,657	13
14	22	Employee Benefits & Payroll	Resident Days	331,413	13	11,527	21,071	733	14
15	23	Inservice Training & Education	Resident Days	331,413	13		21,071		15
16	24	Travel and Seminar	Resident Days	331,413	13	1,299	21,071	83	16
17	25	Other Admin. Staff Transport.	Resident Days	331,413	13	29,621	21,071	1,883	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	331,413	13	18,001	21,071	1,144	18
19	27	Mgmt. Allocation of Benefits	Resident Days	331,413	13		21,071		19
20	30	Depreciation	Resident Days	331,413	13	236,686	21,071	15,048	20
21	32	Interest	Resident Days	331,413	13	333,393	21,071	21,197	21
22	33	Real Estate Taxes	Resident Days	331,413	13		21,071		22
23	34	Rent-Facility and Grounds	Resident Days	331,413	13		21,071		23
24	35	Rent-Equipment & Vehicles	Resident Days	331,413	13	1,756	21,071	112	24
25	TOTALS					\$ 829,849	\$	\$ 52,761	25

Facility Name &amp; ID Number

Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	US Bank		X	Mortgage	Varies	1/4/2005	\$ 1,180,000	\$ 1,057,917	2/18/2011	0.0699	\$ 74,932	1								
2												2								
3							Interest Offset				(59)	3								
4							Home Office Allocation-PHC				2,804	4								
5							Home Office Allocation-PHC II				21,197	5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 1,180,000	\$ 1,057,917			\$ 98,874	9								
<b>B. Non-Facility Related*</b>																				
10							Amortization of Loan Costs				265	10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 265	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 1,180,000	\$ 1,057,917			\$ 99,139	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.)

\*\* 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**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	<b>22,500</b>	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.)	2007	\$	<b>23,831</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>1,331</b>	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>25,000</b>	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>Home Office Allocation</b>			<b>535</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>26,866</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>17,454</b>	8
	2004	<b>18,151</b>	9
	2005	<b>20,831</b>	10
	2006	<b>21,817</b>	11
	2007	<b>23,831</b>	12

Accrual based on prior year tax bill.

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 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.

**2007 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 2007 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 2007.

(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>Long-Term Care Facility</u>	\$ <u>23,831.44</u>	\$ <u>23,831.44</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>23,831.44</u>	\$ <u>23,831.44</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**PLEASE NOTE:** Payment information from the Internet or otherwise is not considered acceptable tax bill documentation. Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Casey Health Care Center

# 0046714 Report Period Beginning:

1/1/2008 Ending:

12/31/2008

**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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  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:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>225,000</u>	<u>2004</u>	<u>\$ 35,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>225,000</b>		<b>\$ 35,000</b>	<b>3</b>

**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 BHF 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	\$	35	\$ 25,714	\$ 25,714	\$ 109,285	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Sidewalks		2004	4,990		15	333	333	1,358	9
10	Sidewalks		2005	4,885		15	326	326	1,141	10
11	Carpentry		2005	7,356		30	245	245	960	11
12	Alarm System		2005	13,492		10	1,349	1,349	4,497	12
13	A/C Unit		2006	4,978		10	498	498	1,245	13
14	Sign		2006	580		10	58	58	145	14
15	Roof Repair		2006	7,560		20	378	378	944	15
16	Sidewalks		2007	3,216		15	214	214	321	16
17	Blinds		2007	2,070		10	207	207	311	17
18	Smoke Detectors		2007	1,432		10	143	143	215	18
19	Asphalt Resurfacing		2008	48,000		15	1,600	1,600	1,600	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43			36,109			(36,109)		43
44			4,663			(4,663)		44
45								45
46								46
47		732			47	47		47
48		10,941			262	262		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		\$ 1,010,232	\$ 40,772		\$ 31,374	\$ (9,398)	\$ 122,022	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 196,054	\$ 28,562	\$ 19,606	\$ (8,956)		\$ 84,114	71
72	Current Year Purchases	1,551	129	78	(51)		78	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			19,034	19,034			74
75	TOTALS	\$ 197,605	\$ 28,691	\$ 38,718	\$ 10,027		\$ 84,192	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,242,837	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 69,463	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,092	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 629	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 206,214	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

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

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

**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: \$ 9,015 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

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

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford E250 Van	\$ 1,477	\$ 17,728	17
18					18
19					19
20					20
21	TOTAL		\$ 1,477.00	\$ 17,728	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2011 \$ \_\_\_\_\_

\* 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.

**Casey Health Care Center**

**0046714**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 5,177
Copier	3,270
Home Office Allocation	568
	<u>9,015</u>
	<u><u>9,015</u></u>

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

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service			Units	Cost									
1	Licensed Occupational Therapist	10A(3)	hrs			1,167	\$ 17,502					1,167	\$	17,502		1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs			1,327	19,909					1,327		19,909		2
3	Licensed Recreational Therapist	10A(2)	hrs													3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs			10,345	155,168			167		10,345		155,335		4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39(2)	# of prescripts							43,287				43,287		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	<b>TOTAL</b>				\$	12,839	\$ 192,579	\$	43,454			12,839	\$	236,033		14

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



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>823,756</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>1</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>823,757</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>546,832</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>546,832</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>1,370,589</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 2,403,259	1
2	Discounts and Allowances for all Levels	48,258	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,451,517	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	257,509	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 257,509	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,907	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	69,603	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,149	20
21	Other Medical Services	5,963	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 79,622	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	59	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 59	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Meals on Wheels Revenue	2,090	28
28a	Miscellaneous Revenue	1,332	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,422	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,792,129	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	513,840	31
32	Health Care	1,055,761	32
33	General Administration	353,361	33
	<b>B. Capital Expense</b>		
34	Ownership	197,166	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	87,285	35
36	Provider Participation Fee	37,884	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,245,297	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	546,832	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 546,832	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. Facility is part of larger entity.

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

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

Facility Name & ID Number Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

**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	\$ 52,012	\$ 25.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,592	3,751	84,667	22.57	3
4	Licensed Practical Nurses	11,114	11,634	201,151	17.29	4
5	CNAs & Orderlies	38,943	40,223	381,090	9.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,665	1,845	22,416	12.15	9
10	Activity Assistants					10
11	Social Service Workers	1,235	1,291	12,083	9.36	11
12	Dietician					12
13	Food Service Supervisor	1,127	1,127	10,704	9.50	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,518	10,782	95,448	8.85	15
16	Dishwashers					16
17	Maintenance Workers	1,968	2,100	31,136	14.83	17
18	Housekeepers	10,850	11,063	94,678	8.56	18
19	Laundry	984	1,012	8,102	8.01	19
20	Administrator	2,080	2,080	53,090	25.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	24,405	11.73	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coord.</u>	1,990	2,101	41,408	19.71	33
34	TOTAL (lines 1 - 33)	90,226	93,169	\$ 1,112,390 *	\$ 11.94	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 9,750	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 3,000	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	TOTAL (lines 35 - 48)	\$ 12,750		49

**C. CONTRACT NURSES**

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



**Casey Health Care Center**

**0046714**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		5,607

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	120
GoffWilson, P.A.	Legal	399
U.S. Bank	Legal	697
Ginoli & Company	Accountants	3,510
RSM McGladrey	Accountants	9
U.S. Bank	Accountants	428
Emdeon Business Services	Computer Services	47
Advanced Answers on Demand	Computer Services	64
Access 2 Go	Computer Services	756
Ivans	Computer Services	728
Kemper Technology	Computer Services	116
VisionShare	Computer Services	409
Logmein	Computer Services	44
Comm Net Communiations	Computer Services	32
Charter Communications	Computer Services	12
Advanced System Designs	Computer Services	10
Consolidated Communications	Computer Services	15
Miscellaneous Vendors	Computer Services	9
CDW	Computer Services	213
Miscellaneous Vendors	Miscellaneous	56

Total (agree to Schedule V, line 19, column 8)		<u>13,281</u>
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**Casey Health Care Center**

**0046714**

**Period Beginning 1/1/2008**

**Period End 12/31/2008**

**XIX. SUPPORT SCHEDULES**

**Schedule 21B**

**A. Administrative Salaries**

<u>Name</u>	<u>Function</u>	<u>Ownership %</u>	<u>Amount</u>
Kathy Moore	Administrator	0	53,090
	<b>Total</b>		<u>53,090</u>



Facility Name & ID Number Casey Health Care Center# 0046714

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. 2,020 -IHCA
- (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? No
- (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 expense and the location of this expense on Sch. V. \$ 9,767 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? N/A  
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. \$ 37,884  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,997
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
- 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? N/A**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ No**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, 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