

Facility Name & ID Number Casey Health Care Center# 0046714 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	<u>69</u>	Skilled (SNF)	<u>69</u>	<u>25,185</u>	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	<u>69</u>	TOTALS	<u>69</u>	<u>25,185</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	<u>14,372</u>	<u>7,904</u>	<u>1,276</u>	<u>23,552</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,372</u>	<u>7,904</u>	<u>1,276</u>	<u>23,552</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.52%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 WheelsF. Does the facility maintain a daily midnight census? YesG. 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 7H. 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 7/1/2004J. 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 1,249Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Casey Health Care Center # 0046714 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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
	A. General Services										
1	Dietary	107,420	13,352		120,772		120,772	4,119	124,891		1
2	Food Purchase		125,885		125,885		125,885	(8,608)	117,277		2
3	Housekeeping	108,799	25,008		133,807		133,807	39	133,846		3
4	Laundry	39	9,264		9,303		9,303		9,303		4
5	Heat and Other Utilities			86,253	86,253		86,253	407	86,660		5
6	Maintenance	32,198	6,841	19,462	58,501		58,501	2,039	60,540		6
7	Other (specify):* Home Off. Ben. All.							744	744		7
8	TOTAL General Services	248,456	180,350	105,715	534,521		534,521	(1,260)	533,261		8
	B. Health Care and Programs										
9	Medical Director			9,500	9,500		9,500		9,500		9
10	Nursing and Medical Records	836,440	64,615	30,209	931,264		931,264	1,722	932,986		10
10a	Therapy			306,771	306,771		306,771		306,771		10a
11	Activities	25,418	533	517	26,468		26,468		26,468		11
12	Social Services	22,799			22,799		22,799		22,799		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							307	307		15
16	TOTAL Health Care and Programs	884,657	65,148	346,997	1,296,802		1,296,802	2,029	1,298,831		16
	C. General Administration										
17	Administrative	12,273		139,000	151,273		151,273	(98,000)	53,273		17
18	Directors Fees										18
19	Professional Services			5,790	5,790		5,790	15,513	21,303		19
20	Dues, Fees, Subscriptions & Promotions			4,302	4,302		4,302	2,798	7,100		20
21	Clerical & General Office Expenses	25,390	6,499	8,546	40,435		40,435	49,334	89,769		21
22	Employee Benefits & Payroll Taxes			219,743	219,743		219,743	6,045	225,788		22
23	Inservice Training & Education			129	129		129	601	730		23
24	Travel and Seminar			35	35		35	132	167		24
25	Other Admin. Staff Transportation			4,395	4,395		4,395	5,101	9,496		25
26	Insurance-Prop.Liab.Malpractice			24,073	24,073		24,073	859	24,932		26
27	Other (specify):* Home Off. Ben. All.							11,273	11,273		27
28	TOTAL General Administration	37,663	6,499	406,013	450,175		450,175	(6,344)	443,831		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,170,776	251,997	858,725	2,281,498		2,281,498	(5,575)	2,275,923		29

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

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

Facility Name & ID Number

Casey Health Care Center

#0046714

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	
	D. Ownership											
30	Depreciation			72,177	72,177		72,177	4,673	76,850			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			73,672	73,672		73,672	25,772	99,444			32
33	Real Estate Taxes			25,297	25,297		25,297	522	25,819			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,136	12,136		12,136	501	12,637			35
36	Other (specify):*											36
37	TOTAL Ownership			183,282	183,282		183,282	31,468	214,750			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		50,128		50,128		50,128		50,128			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,778	37,778		37,778		37,778			42
43	Other (specify):* Non-allowable Cost		1,280	25,524	26,804		26,804	(26,804)				43
44	TOTAL Special Cost Centers		51,408	63,302	114,710		114,710	(26,804)	87,906			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,170,776	303,405	1,105,309	2,579,490		2,579,490	(911)	2,578,579			45

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

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,794)	2		4
5	Telephone, TV & Radio in Resident Rooms	(851)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,224)	30		9
10	Interest and Other Investment Income	(221)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(102)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(186)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,821)	43		24
25	Fund Raising, Advertising and Promotional	(2,773)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(10,924)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (55,896)		\$	30

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)	#REF!	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ #REF!		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ #REF!		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Casey Health Care Center

ID# 0046714

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (481)	43	1
2	X-Rays-Part A	(804)	43	2
3	Disallowed Special Events	(1,466)	43	3
4	Resident Flowers	(320)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(175)	21	5
6	Offset Meals on Wheels Revenue	(6,907)	2	6
7	Offset Miscellaneous Nursing Supplies Revenue	(771)	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
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(10,924)		49

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 <u>Dues, Fees, Subs and Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 1,609	\$	1,609	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	41,998		41,998	16
17	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	429		429	17
18	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	132		132	18
19	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	2,070		2,070	19
20	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	859		859	20
21	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	11,273		11,273	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,395		3,395	22
23	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	5,221		5,221	23
24	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	522		522	24
25	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	499		499	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		\$			\$ 68,007	\$ *	68,007	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
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%	44	44	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%	9,738	9,738	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,189	1,189	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	7,511	7,511	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	6,045	6,045	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	172	172	29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,031	3,031	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		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%	20,502	20,502	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	20,772	20,772	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%	2	2	38	
39	Total		\$			\$ 69,006	\$ *	69,006	39

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

Facility Name & ID Number

Casey Health Care Center

0046714

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	156,435	0.92	1.53	Salary	\$ 2,678	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	\$ 2,678		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:

1/1/2009

Ending: 2/31/2009

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

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

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

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	1,493,044	75	\$ 261,102	\$ 259,584	23,552	\$ 4,119	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	23,552	93	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	23,552	39	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	23,552	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	23,552	407	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	23,552	1,995	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	23,552	744	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	23,552	2,493	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	23,552	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	23,552	307	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	23,552	41,000	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	23,552	5,775	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	23,552	1,609	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	23,552	41,998	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	23,552	429	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	23,552	132	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	23,552	2,070	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	23,552	859	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	23,552	11,273	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	23,552	3,395	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	23,552	5,221	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	23,552	522	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	23,552	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	23,552	499	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 124,979	25

Facility Name & ID Number Casey Health Care Center# 0046714 Report Period Beginning: 1/1/2009Ending: 2/31/2009

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	336,837	13	\$	\$	23,552	\$	1
2	2	Food	Resident Days	336,837	13			23,552		2
3	3	Housekeeping	Resident Days	336,837	13			23,552		3
4	4	Laundry	Resident Days	336,837	13			23,552		4
5	5	Utilities	Resident Days	336,837	13			23,552		5
6	6	Maintenance	Resident Days	336,837	13	628		23,552	44	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,837	13			23,552		7
8	10	Nursing and Medical Records	Resident Days	336,837	13			23,552		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,837	13			23,552		9
10	17	Administrative	Resident Days	336,837	13			23,552		10
11	19	Professional Services	Resident Days	336,837	13	139,269		23,552	9,738	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,837	13	17,001		23,552	1,189	12
13	21	Clerical and General Office	Resident Days	336,837	13	107,426		23,552	7,511	13
14	22	Employee Benefits & Payroll	Resident Days	336,837	13	86,458		23,552	6,045	14
15	23	Inservice Training & Education	Resident Days	336,837	13	2,464		23,552	172	15
16	24	Travel and Seminar	Resident Days	336,837	13			23,552		16
17	25	Other Admin. Staff Transport.	Resident Days	336,837	13	43,354		23,552	3,031	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,837	13			23,552		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,837	13			23,552		19
20	30	Depreciation	Resident Days	336,837	13	293,215		23,552	20,502	20
21	32	Interest	Resident Days	336,837	13	297,084		23,552	20,772	21
22	33	Real Estate Taxes	Resident Days	336,837	13			23,552		22
23	34	Rent-Facility and Grounds	Resident Days	336,837	13			23,552		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,837	13	26		23,552	2	24
25	TOTALS					\$ 986,925	\$		\$ 69,006	25

Facility Name & ID Number

Casey Health Care Center

0046714

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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										
										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			
A. Directly Facility Related																			
Long-Term																			
1	US Bank	X	Mortgage	Varies	1/4/2005	\$ 1,180,000	\$ 1,021,020	2/18/2011	0.0699	\$ 73,407	1								
2											2								
3						Interest Income Offset				(221)	3								
4						Home Office Allocation-PHC				5,221	4								
5						Home Office Allocation-PHC II				20,772	5								
Working Capital																			
6											6								
7											7								
8											8								
9	TOTAL Facility Related					\$ 1,180,000	\$ 1,021,020			\$ 99,179	9								
B. Non-Facility Related*																			
10						Amortization of Loan Costs				265	10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related					\$	\$			\$ 265	14								
15	TOTALS (line 9+line14)					\$ 1,180,000	\$ 1,021,020			\$ 99,444	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.)

Facility Name & ID Number Casey Health Care Center

0046714

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	TOTALS	225,000		\$ 35,000	3

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	\$ 134,999	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Sidewalks		2004	4,990		15	333	333	1,691	9
10	Sidewalks		2005	4,885		15	326	326	1,467	10
11	Carpentry		2005	7,356		30	245	245	1,205	11
12	Alarm System		2005	13,492		10	1,349	1,349	5,846	12
13	A/C Unit		2006	4,978		10	498	498	1,743	13
14	Sign		2006	580		10	58	58	203	14
15	Roof Repair		2006	7,560		20	378	378	1,322	15
16	Sidewalks		2007	3,216		15	214	214	535	16
17	Blinds		2007	2,070		10	207	207	518	17
18	Smoke Detectors		2007	1,432		10	143	143	358	18
19	Asphalt Resurfacing		2008	48,000		15	3,200	3,200	4,800	19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27	Land Improvements Booked				4,073			(4,073)		27
28	Building Booked				36,109			(36,109)		28
29	Building Improvement Booked				3,257			(3,257)		29
30										30
31										31
32	2009-Home Office Allocation-Land Improvements			775			49	49		32
33	2009-Home Office Allocation-Building Improvements			11,578			278	278		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								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)	\$ 1,010,912	\$ 43,439		\$ 32,992	\$ (10,447)	\$ 154,687	70

**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:

1/1/2009

Ending:

12/31/2009

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	\$ 197,605	\$ 28,500	\$ 19,761	\$ (8,739)	7-10 yrs.	\$ 103,953	71
72	Current Year Purchases	3,992	238	200	(38)	10 yrs.	200	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			23,897	23,897			74
75	TOTALS	\$ 201,597	\$ 28,738	\$ 43,858	\$ 15,120		\$ 104,153	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)	\$ 1,247,509	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,177	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,850	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,673	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 258,840	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: \$ 5,774 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	2006 Ford E250	\$ 578.17	\$ 6,863	17
18					18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 6,863	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 1/1/2009
Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 2,503
Copier	2,770
Home Office Allocation	501
	<hr/>
	5,774
	<hr/> <hr/>

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?</p> <p><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		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	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	10A(3)	hrs	\$	2,428	\$ 36,419	\$	2,428	\$ 36,419	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,269	19,032		1,269	19,032	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		16,740	251,100		16,740	251,100	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				50,128		50,128	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>	10(3)			15	220		15	220	13
14	TOTAL			\$	20,452	\$ 306,771	\$ 50,128	20,452	\$ 356,899	14

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

Facility Name & ID Number Casey Health Care Center# 0046714Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,275,443	\$ 2,275,443	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>50,000</u>)	322,948	322,948	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,990	34,990	6
7	Other Prepaid Expenses	11,884	11,884	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	3,865	3,865	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,649,130	\$ 2,649,130	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	96,091	35,000	13
14	Buildings, at Historical Cost	900,000	911,578	14
15	Leasehold Improvements, at Historical Cost	29,328	99,334	15
16	Equipment, at Historical Cost	205,418	201,597	16
17	Accumulated Depreciation (book methods)	(348,142)	(258,840)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Loan Costs</u>)	530	530	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 883,225	\$ 989,199	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,532,355	\$ 3,638,329	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 302,134	\$ 302,134	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,165	73,165	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,278	2,278	31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,500	25,500	32
33	Accrued Interest Payable	6,430	6,430	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	53,356	53,356	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 462,863	\$ 462,863	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,021,020	1,021,020	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,021,020	\$ 1,021,020	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,483,883	\$ 1,483,883	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,048,472	\$ 2,154,446	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,532,355	\$ 3,638,329	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,370,589	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(50,000)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,320,589	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	727,883	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 727,883	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,048,472	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Casey Health Care Center

0046714

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,832,331	1
2	Discounts and Allowances for all Levels	(29,295)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,803,036	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	413,167	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 413,167	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,794	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	78,113	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,381	20
21	Other Medical Services	1,808	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 83,096	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	221	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 221	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Meals on Wheels Revenue	6,907	28
28a	Miscellaneous Revenue	946	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,853	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,307,373	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	534,521	31
32	Health Care	1,296,802	32
33	General Administration	450,175	33
B. Capital Expense			
34	Ownership	183,282	34
C. Ancillary Expense			
35	Special Cost Centers	76,932	35
36	Provider Participation Fee	37,778	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,579,490	40
41	Income before Income Taxes (line 30 minus line 40)**	727,883	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 727,883	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:

1/1/2009

Ending:

12/31/2009

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	\$ 56,670	\$ 27.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,515	3,678	83,769	22.78	3
4	Licensed Practical Nurses	11,768	12,286	219,697	17.88	4
5	CNAs & Orderlies	42,277	43,650	434,055	9.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,954	2,098	23,324	11.12	9
10	Activity Assistants					10
11	Social Service Workers	1958	2,088	22,799	10.92	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	20,052	9.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,634	10,053	87,368	8.69	15
16	Dishwashers					16
17	Maintenance Workers	1,807	2,083	32,198	15.46	17
18	Housekeepers	12,459	12,705	108,799	8.56	18
19	Laundry	5	5	39	7.80	19
20	Administrator	2,080	2,080	50,595	24.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,971	2,098	25,390	12.10	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 C: CPC	1,856	2,041	42,249	20.70	32
33	Other(specify) <u>Transportation</u>	235	235	2,094	8.91	33
34	TOTAL (lines 1 - 33)	95,679	99,260	\$ 1,209,098 *	\$ 12.18	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 9,500	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 3,600	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)	\$ 13,100		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 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,790

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	37
GoffWilson, P.A.	Legal	52
Jackson Lewis	Legal	414
Peter Gartelos	Legal	40
Misc.	Legal	36
Ginoli & Company	Accountants	2,733
Miscellaneous Vendors	Computer Services	38
Emdeon Business Services	Computer Services	17
Advanced Answers on Demand	Computer Services	2,219
Access 2 Go	Computer Services	213
Ivans	Computer Services	132
Kemper Technology	Computer Services	603
VisionShare	Computer Services	188
MediFax	Computer Services	77
LogmeIn	Computer Services	33
Charter Communications	Computer Services	1
CDW	Computer Services	336
Simple LTC	Computer Services	512
Polaris Group	Other Professional Services	7,353
Donna Howard & Assoc.	Other Professional Services	126
Miscellaneous Vendors	Miscellaneous	353
Total (agree to Schedule V, line 19, column 8)		<u>21,303</u>

Facility Name & ID Number Casey Health Care Center

0046714

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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. 1,500 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. \$ 15,516 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. \$ 37,778
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 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. \$ 8,701
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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.