



Facility Name & ID Number Casey Health Care Center

# 0046714 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

**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	69	Skilled (SNF)	69	25,185	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	25,185	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	11,697	6,230	2,127	20,054	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,697	6,230	2,127	20,054	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.63%

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 1,497

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: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name &amp; ID Number

Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

## 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	118,496	14,548		133,044		133,044	4,046	137,090		1
2	Food Purchase		128,347		128,347		128,347	(10,270)	118,077		2
3	Housekeeping	118,191	22,123		140,314		140,314	26	140,340		3
4	Laundry		5,486		5,486		5,486		5,486		4
5	Heat and Other Utilities			103,734	103,734		103,734	265	103,999		5
6	Maintenance	34,005	6,511	16,670	57,186		57,186	3,030	60,216		6
7	Other (specify):* Home Off. Ben. All.							922	922		7
8	<b>TOTAL General Services</b>	270,692	177,015	120,404	568,111		568,111	(1,981)	566,130		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			11,250	11,250		11,250		11,250		9
10	Nursing and Medical Records	868,422	76,271	4,321	949,014		949,014	41	949,055		10
10a	Therapy			302,552	302,552		302,552		302,552		10a
11	Activities	30,031	571	160	30,762		30,762	(621)	30,141		11
12	Social Services	20,277	65		20,342		20,342		20,342		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	<b>TOTAL Health Care and Programs</b>	918,730	76,907	318,283	1,313,920		1,313,920	(580)	1,313,340		16
	<b>C. General Administration</b>										
17	Administrative			180,000	180,000		180,000	(130,000)	50,000		17
18	Directors Fees										18
19	Professional Services			5,567	5,567		5,567	7,585	13,152		19
20	Dues, Fees, Subscriptions & Promotions			1,973	1,973		1,973	390	2,363		20
21	Clerical & General Office Expenses	20,041	4,312	5,955	30,308		30,308	43,281	73,589		21
22	Employee Benefits & Payroll Taxes			137,561	137,561		137,561		137,561		22
23	Inservice Training & Education							135	135		23
24	Travel and Seminar							40	40		24
25	Other Admin. Staff Transportation			4,940	4,940		4,940	7,163	12,103		25
26	Insurance-Prop.Liab.Malpractice			23,953	23,953		23,953	938	24,891		26
27	Other (specify):* Home Off. Ben. All.							15,329	15,329		27
28	<b>TOTAL General Administration</b>	20,041	4,312	359,949	384,302		384,302	(55,139)	329,163		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,209,463	258,234	798,636	2,266,333		2,266,333	(57,700)	2,208,633		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 &amp; ID Number

Casey Health Care Center

#0046714

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

## 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			72,966	72,966		72,966	3,276	76,242			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			65,218	65,218		65,218	39,184	104,402			32
33	Real Estate Taxes			25,984	25,984		25,984	333	26,317			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			20,336	20,336		20,336	593	20,929			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			184,504	184,504		184,504	43,386	227,890			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		140,087		140,087		140,087		140,087			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):* <b>Non-allowable Costs</b>		2,312	125,655	127,967		127,967	(127,967)				43
44	<b>TOTAL Special Cost Centers</b>		142,399	163,433	305,832		305,832	(127,967)	177,865			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,209,463	400,633	1,146,573	2,756,669		2,756,669	(142,281)	2,614,388			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	(7,928)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,005)	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	(16,490)	30		9
10	Interest and Other Investment Income	(1,004)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(567)	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	(4,369)	43		18
19	Entertainment				19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(106,248)	43		24
25	Fund Raising, Advertising and Promotional	(4,704)	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 Page 5A	(14,487)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (157,002)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	14,721	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 14,721		36
	(sum of SUBTOTALS)			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ (142,281)		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		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Casey Health Care Center

ID# 0046714

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,877)	43	1
2	X-Rays-Part A	(2,919)	43	2
3	Offset Meals on Wheels Food Revenue	(2,361)	2	3
4	Offset Miscellaneous Office Supplies Revenue	(481)	21	4
5	Offset Chamber of Commerce Dues	(150)	20	5
6	Resident Flowers	(308)	43	6
7	Disallowed Special Events	(770)	43	7
8	Offset Transportation Revenue	(621)	11	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(14,487)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6 - Supp		See PG6 - Supp		

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%	\$ 4,046	\$ 4,046	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	19	19	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	26	26	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	265	265	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,650	1,650	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	922	922	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	41	41	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17 Administrative	180,000	Petersen Health Care, Inc.	100.00%	50,000	(130,000)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,628	4,628	12
13	V							13
14	Total		\$ 180,000			\$ 61,597	\$ * (118,403)	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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 325	\$	325	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	37,715		37,715	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	135		135	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	40		40	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,466		3,466	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	938		938	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	15,329		15,329	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,419		5,419	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,522		6,522	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	333		333	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	591		591	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		\$			\$ 70,813	\$ *	70,813	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%	1,380		1,380
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	12	Social Services		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%	2,957		2,957
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	215		215
27	V	21	Clerical and General Office		Petersen Health Care II, Inc.	100.00%	6,047		6,047
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	0		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%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	3,697		3,697
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%	14,347		14,347
35	V	32	Interest		Petersen Health Care II, Inc.	100.00%	33,666		33,666
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
39	Total			\$			\$ 62,311	\$ *	62,311

\* 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:

1/1/2011

Ending:

12/31/2011

## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

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## VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

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Ending:

12/31/2011

**VII. RELATED PARTIES**

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				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

Facility Name & ID Number

Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2011

Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, L	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health System	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants,	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care V	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care V	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care V	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfo	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LL	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name &amp; ID Number

Casey Health Care Center

#

0046714

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

## 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												1
2	N/A											2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13								TOTAL	\$			13

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

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

Facility Name & ID Number Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2011

Ending: 2/31/2011

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	1,542,131	77	\$ 311,109	\$ 308,619	20,054	\$ 4,046	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	20,054	19	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	20,054	26	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	20,054	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	20,054	265	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	20,054	1,650	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	20,054	922	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	20,054	41	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	20,054	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	20,054	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	20,054	50,000	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	20,054	4,628	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	20,054	325	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	20,054	37,715	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	20,054	135	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	20,054	40	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	20,054	3,466	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	20,054	938	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	20,054	15,329	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	20,054	5,419	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	20,054	6,522	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	20,054	333	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	20,054	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	20,054	591	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 132,410	25

Facility Name & ID Number Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2011

Ending: 2/31/2011

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 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

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	325,902	13	\$	\$	20,054	\$	1
2	2	Food	Resident Days	325,902	13			20,054		2
3	3	Housekeeping	Resident Days	325,902	13			20,054		3
4	4	Laundry	Resident Days	325,902	13			20,054		4
5	5	Utilities	Resident Days	325,902	13			20,054		5
6	6	Maintenance	Resident Days	325,902	13	22,420		20,054	1,380	6
7	7	Mgmt. Allocation of Benefits	Resident Days	325,902	13			20,054		7
8	10	Nursing and Medical Records	Resident Days	325,902	13			20,054		8
9	15	Mgmt. Allocation of Benefits	Resident Days	325,902	13			20,054		9
10	17	Administrative	Resident Days	325,902	13			20,054		10
11	19	Professional Services	Resident Days	325,902	13	48,058		20,054	2,957	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	325,902	13	3,502		20,054	215	12
13	21	Clerical and General Office	Resident Days	325,902	13	98,273		20,054	6,047	13
14	22	Employee Benefits & Payroll	Resident Days	325,902	13			20,054		14
15	23	Inservice Training & Education	Resident Days	325,902	13			20,054		15
16	24	Travel and Seminar	Resident Days	325,902	13			20,054		16
17	25	Other Admin. Staff Transport.	Resident Days	325,902	13	60,087		20,054	3,697	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	325,902	13			20,054		18
19	27	Mgmt. Allocation of Benefits	Resident Days	325,902	13			20,054		19
20	30	Depreciation	Resident Days	325,902	13	233,155		20,054	14,347	20
21	32	Interest	Resident Days	325,902	13	547,113		20,054	33,666	21
22	33	Real Estate Taxes	Resident Days	325,902	13			20,054		22
23	34	Rent-Facility and Grounds	Resident Days	325,902	13			20,054		23
24	35	Rent-Equipment & Vehicles	Resident Days	325,902	13	36		20,054	2	24
25	TOTALS					\$ 1,012,644	\$		\$ 62,311	25

Facility Name & ID Number

Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

**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			
										Amount of Note		Reporting Period Interest Expense
Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)			
		YES	NO									
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	US Bank		X	Mortgage	Varies	1/4/2005	\$ 1,180,000	\$ 939,032	2/18/2011	0.0699	\$ 64,953	1
2												2
3										Interest Income Offset	(1,004)	3
4										Home Office Allocation-PHC	6,522	4
5										Home Office Allocation-PHC II	33,666	5
<b>Working Capital</b>												
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 1,180,000	\$ 939,032			\$ 104,137	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	\$ 939,032			\$ 104,402	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**

		<b>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</b>				
1.	Real Estate Tax accrual used on 2010 report.			\$	26,640	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.)	2010		\$	25,924	2
3.	Under or (over) accrual (line 2 minus line 1).			\$	(716)	3
4.	Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	26,700	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$		5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		Home Office Allocation		333	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	26,317	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	21,817	8		
		2007	23,831	9		
		2008	24,797	10		
		2009	25,813	11		
		2010	25,924	12		
<u>Accrual based on prior year tax bill.</u>						
		<b>FOR BHF USE ONLY</b>				
		13	FROM R. E. TAX STATEMENT FOR 2010	\$		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.**

**2010 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 2010 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 2010.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>03-11-17-20-403-005</u>	<u>Long-Term Care Facility</u>	\$ <u>25,924.10</u>	\$ <u>25,924.10</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>25,924.10</u></u>	\$ <u><u>25,924.10</u></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  NO

If YES, attach an explanation and 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

**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.

**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>

Facility Name & ID Number Casey Health Care Center# 0046714

Report Period Beginning:

1/1/2011

Ending:

12/31/2011**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-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	\$ 186,427	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Sidewalks		2004	4,990		15	333	333	2,357	9
10	Sidewalks		2005	4,885		15	326	326	2,119	10
11	Carpentry		2005	7,356		30	245	245	1,695	11
12	Alarm System		2005	13,492		10	1,349	1,349	8,544	12
13	A/C Unit		2006	4,978		10	498	498	2,739	13
14	Sign		2006	580		10	58	58	319	14
15	Roof Repair		2006	7,560		20	378	378	2,078	15
16	Sidewalks		2007	3,216		15	214	214	963	16
17	Blinds		2007	2,070		10	207	207	932	17
18	Smoke Detectors		2007	1,432		10	143	143	644	18
19	Asphalt Resurfacing		2008	48,000		15	3,200	3,200	11,200	19
20	Water Heater		2010	3,763		10	376	376	564	20
21	Sprinkler System		2011	92,400		25	1,848	1,848	1,848	21
22										22
23										23
24										24
25										25
26										26
27										27
28	Land Improvements Booked				4,073			(4,073)		28
29	Building Booked				36,109			(36,109)		29
30	Building Improvement Booked				5,908			(5,908)		30
31										31
32										32
33										33
34	2011-Home Office Allocation-Building Improvements			9,545			229	229		34
35	2011-Home Office Allocation-Land Improvements			891			57	57		35
36										36

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

See Page 12A, Line 70 for total

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

**XI. OWNERSHIP COSTS (continued)**

**B. Building and Improvement Costs-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	<b>TOTAL (lines 4 thru 69)</b>	\$	\$		\$	\$	\$	70
			1,105,158	46,090	35,175	(10,915)	222,429	

\*\*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:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$ 213,003	\$ 26,876	\$ 21,301	\$ (5,575)	7-10 yrs.	\$ 146,184	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			19,766	19,766			74
75	TOTALS	\$ 213,003	\$ 26,876	\$ 41,067	\$ 14,191		\$ 146,184	75

D. Vehicle Costs. (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	N/A									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)	\$ 1,353,161	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 72,966	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 76,242	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 3,276	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 368,613	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.

Facility Name & ID Number Casey Health Care Center

STATE OF ILLINOIS  
# 0046714

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

**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	<b>TOTAL</b>				\$			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: \$ 14,066

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	\$ 571.88	\$ 6,863	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ 571.88	\$ 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. \_\_\_\_\_/2012 \$ \_\_\_\_\_

13. \_\_\_\_\_/2013 \$ \_\_\_\_\_

14. \_\_\_\_\_/2014 \$ \_\_\_\_\_

\* 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**

1/1/2011

**Period End**

12/31/2011

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$	10,449
Dishwasher		-
Laundry Equipment		-
Copier		3,024
Home Office Allocation		593
		<u>14,066</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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></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		Contract	Total
		1 Drop-outs	2 Completed		
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**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
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		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,118	\$	91,770	\$	6,118	\$	91,770	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,975		29,627		1,975		29,627	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10A(3)	hrs		12,077		181,155		12,077		181,155	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					140,087			140,087	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>			\$	20,170	\$	302,552	\$	140,087	\$	442,639	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 &amp; ID Number Casey Health Care Center

# 0046714

Report Period Beginning: 1/1/2011

Ending:

12/31/2011

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 3,691,081	\$ 3,691,081	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 155,000 )	692,206	692,206	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,387	19,387	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>	2,815	2,815	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 4,417,373	\$ 4,417,373	10
<b>B. Long-Term Assets</b>				
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	909,545	14
15	Leasehold Improvements, at Historical Cost	125,491	195,613	15
16	Equipment, at Historical Cost	216,824	213,003	16
17	Accumulated Depreciation (book methods)	(494,251)	(368,613)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 844,155	\$ 984,548	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 5,261,528	\$ 5,401,921	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 952,178	\$ 952,178	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	75,053	75,053	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,229	5,229	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,700	26,700	32
33	Accrued Interest Payable	2,240	2,240	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Payroll Withholdings</u>	59,757	59,757	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,121,157	\$ 1,121,157	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable	939,032	939,032	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 939,032	\$ 939,032	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,060,189	\$ 2,060,189	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 3,201,339	\$ 3,341,732	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 5,261,528	\$ 5,401,921	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,826,631	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,826,630	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	374,709	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)	\$ 374,709	17
<b>B. Transfers (Itemize):</b>			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,201,339	24 *

\* 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	\$ 2,661,488	1
2	Discounts and Allowances for all Levels	(210,194)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 2,451,294</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	453,250	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 453,250</b>	<b>8</b>
<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	7,928	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	203,763	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,962	20
21	Other Medical Services	3,714	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 222,367</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,004	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 1,004</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Meals on Wheels Revenue	2,361	28
28a	Miscellaneous & Transportation Revenue	1,102	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 3,463</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 3,131,378</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	568,111	31
32	Health Care	1,313,920	32
33	General Administration	384,302	33
<b>B. Capital Expense</b>			
34	Ownership	184,504	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	268,054	35
36	Provider Participation Fee	37,778	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 2,756,669</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>374,709</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 374,709</b>	<b>43</b>

\* 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:

1/1/2011

Ending:

12/31/2011

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	1,839	1,839	\$ 51,633	\$ 28.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,933	5,192	118,370	22.80	3
4	Licensed Practical Nurses	10,720	11,127	205,496	18.47	4
5	CNAs & Orderlies	42,262	43,917	456,393	10.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,032	2,160	25,884	11.98	9
10	Activity Assistants					10
11	Social Service Workers	1,971	1,997	20,277	10.15	11
12	Dietician					12
13	Food Service Supervisor	1,900	1,940	25,326	13.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,435	10,133	93,170	9.19	15
16	Dishwashers					16
17	Maintenance Workers	1,938	2,074	34,005	16.40	17
18	Housekeepers	12,867	13,214	118,191	8.94	18
19	Laundry					19
20	Administrator	2,080	2,080	50,000	24.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,338	1,579	20,041	12.69	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) See Sch 20A	2,374	2,469	40,677	16.48	33
34	TOTAL (lines 1 - 33)	95,689	99,721	\$ 1,259,463 *	\$ 12.63	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	11,250	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,600	L10, C3	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)		\$ 14,850		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

Period Beginning 1/1/2011

Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	1,949	2,044	36,530	17.87
Transportation	425	425	4,147	9.76
<b>TOTAL</b>	<u>2,374</u>	<u>2,469</u>	<u>40,677</u>	

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Kelly Clark	Administrator	0	\$ 50,000	Workers' Compensation Insurance	\$ 21,060	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	21,405	Advertising: Employee Recruitment		
				FICA Taxes	90,120	Health Care Worker Background Check		
				Employee Health Insurance	4,356	(Indicate # of checks performed )		
				Employee Meals		Patient Background Checks	56 560	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	240	
				Employee Relations	52	Miscellaneous Dues & Subscriptions	178	
				Employee Retirement	532	Home Office Allocation	540	
				Life Insurance	36			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						Less: Public Relations Expense	(150)	
						Non-allowable advertising	( )	
						Yellow page advertising	( )	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,363	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL (agree to Schedule V, line 22, col.8)				
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description			Description	
Amount				Line #			Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7				N/A			Out-of-State Travel	
\$ 180,000							\$	
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			Seminar Expense	
\$ 180,000				\$			Home Office Allocation	
							40	
							Entertainment Expense	
							( )	
							TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)							\$ 40	
\$ 5,567								

\* Attach copy of IMRF notifications

\*\*See instructions.

**Casey Health Care Center**

**0046714**

**Period Beginning 1/1/2011**

**Period End 12/31/2011**

**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)		5,567

**Home Office Allocation**

Heyl, Royster, Voelker & Allen	Legal	5
Henry County Recorder	Legal	1
Ginoli & Company	Accountants	643
Miscellaneous Vendors	Computer Services	48
Advanced Answers on Demand	Computer Services	2,685
Access 2 Go	Computer Services	264
Kemper Technology	Computer Services	123
MediFax	Computer Services	42
VisionShare/Ability Network	Computer Services	189
Advanced System Design	Computer Services	247
Simple LTC	Computer Services	310
Optimizer Systems	Other Prof Fees	32
Clifton Gunderson	Other Prof Fees	11
Mike Miller	Other Prof Fees	15
OIC Group	Other Prof Fees	4
AllScripts	Other Prof Fees	8
Miscellaneous Vendors	Legal	2
Ginoli & Company	Accountants	1,063
U.S. Bank	Accountants	612
CDW	Computer Services	654
Polaris Group	Professional Fees	<u>627</u>

Total (agree to Schedule V, line 19, column 8)	<u><u>13,152</u></u>
--	----------------------

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3	N/A											
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	<b>TOTALS</b>	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name &amp; ID Number Casey Health Care Center

# 0046714

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 27,139 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 37,778  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule 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? N/A 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. \$ 7,928
- (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? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 418  
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? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: 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