		FOR BHF USE					

LL1

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0052308

Facility Name: Casey Health Care Center

Address: 100 N E 15th (Number) Casey (City) 62420 (Zip Code)

County: Clark

Telephone Number: (217) 932-5217 **Fax #** (217) 932-5408

HFS ID Number:

Date of Initial License for Current Owners: 10/18/2004

Type of Ownership:

VOLUNTARY,NON-PROFIT	PROPRIETARY	GOVERNMENTAL
[ ] VOLUNTARY,NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code ____	[ ] Corporation	[ ] Other ____
	[ ] "Sub-S" Corp.	
	[X] Limited Liability Co.	
	[ ] Trust	
	[ ] Other ____	

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2015 to 12/31/2015 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) ____ (Date)
	(Type or Print Name) Mark B. Petersen
	(Title) Chief Executive Officer
Paid Preparer	(Signed) ____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	10,659	7,417	2,110	20,186	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,659	7,417	2,110	20,186	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.15%

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 [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/18/2004

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/18/2004 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 69 and days of care provided 1,762

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	133,277	15,162	912	149,351		149,351	3,916	153,267			1
2	Food Purchase		131,210		131,210		131,210	(6,826)	124,384			2
3	Housekeeping	114,703	22,429		137,132		137,132	31	137,163			3
4	Laundry	43	14,040		14,083		14,083		14,083			4
5	Heat and Other Utilities			96,376	96,376		96,376	225	96,601			5
6	Maintenance	38,473	7,811	13,652	59,936		59,936	1,553	61,489			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	286,496	190,652	110,940	588,088		588,088	(1,101)	586,987			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	949,261	62,949	15,751	1,027,961		1,027,961	42	1,028,003			10
10a	Therapy		313	234,379	234,692		234,692		234,692			10a
11	Activities	35,854	189		36,043		36,043	(8,116)	27,927			11
12	Social Services	25,532			25,532		25,532		25,532			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	1,010,647	63,451	262,130	1,336,228		1,336,228	(8,074)	1,328,154			16
	C. General Administration											
17	Administrative			234,900	234,900		234,900	(177,953)	56,947			17
18	Directors Fees											18
19	Professional Services			6,742	6,742		6,742	21,016	27,758			19
20	Dues, Fees, Subscriptions & Promotions			4,611	4,611		4,611	4,206	8,817			20
21	Clerical & General Office Expenses	27,594	2,617	10,722	40,933		40,933	43,786	84,719			21
22	Employee Benefits & Payroll Taxes			168,242	168,242		168,242	29,363	197,605			22
23	Inservice Training & Education							302	302			23
24	Travel and Seminar							69	69			24
25	Other Admin. Staff Transportation			10,534	10,534		10,534	3,082	13,616			25
26	Insurance-Prop.Liab.Malpractice			1,870	1,870		1,870	29,685	31,555			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	27,594	2,617	437,621	467,832		467,832	(46,444)	421,388			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,324,737	256,720	810,691	2,392,148		2,392,148	(55,619)	2,336,529			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 #0052308 **Report Period Beginning:** 1/1/2015 **Ending:** 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			821	821		821	53,641	54,462			30
31	Amortization of Pre-Op. & Org.							6,107	6,107			31
32	Interest							75,269	75,269			32
33	Real Estate Taxes							29,065	29,065			33
34	Rent-Facility & Grounds			182,411	182,411		182,411	(182,411)				34
35	Rent-Equipment & Vehicles			23,514	23,514		23,514	595	24,109			35
36	Other (specify):* Home Office Ben. Allocation											36
37	**TOTAL Ownership**			206,746	206,746		206,746	(17,734)	189,012			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		73,659		73,659		73,659		73,659			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			147,796	147,796		147,796		147,796			42
43	Other (specify):* Home Office Ben. Allocation		720	39,162	39,882		39,882	(39,882)				43
44	**TOTAL Special Cost Centers**		74,379	186,958	261,337		261,337	(39,882)	221,455			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,324,737	331,099	1,204,395	2,860,231		2,860,231	(113,235)	2,746,996			45

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,553)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,197)	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	(8,525)	30		9
10	Interest and Other Investment Income	(51)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(334)	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	(24,991)	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				24
25	Fund Raising, Advertising and Promotional	(2,053)	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	(14,900)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (63,604)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(49,631)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (49,631)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (113,235)		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 Yes	2 No	3 Amount	4 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	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Casey Health Care Center

ID# 0052308

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

NON-ALLOWABLE EXPENSES

		Amount	Sch. V Line Reference	
1	Labs-Part A	$ (2,486)	43	1
2	X-Rays-Part A	(2,744)	43	2
3	Offset Transportation Revenue	(8,116)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(120)	21	4
5	Disallowed Special Events	(77)	43	5
6	Offset Miscellaneous Nursing Supplies Revenue	(78)	10	6
7	Disallowed Meals On Wheels Revenue	(1,110)	2	7
8	Disallowed Vending Machine Revenue	(169)	2	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(14,900)		49

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] 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%	$ 0	$	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	0		3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	0		4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	0		5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		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		Petersen Health Care, Inc.	100.00%	0		11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	197	197	12
13	V								13
14	Total			$			$ 197	$ * 197	14

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] 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%	$ 53	$ 53	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	0		16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	0		17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	0		18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	0		19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	0		20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	0		21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	766	766	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	0		24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	0		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			$			$ 819	$ * 819	39

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Management Company, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Management Company, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Management Company, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Management Company, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Management Company, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Management Company, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Management Company, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Management Company, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Management Company, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Management Company, LLC	100.00%	7,578	7,578	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Management Company, LLC	100.00%	4,029	4,029	26
27	V	21	Clerical and General Office		Petersen Management Company, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Management Company, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Management Company, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Management Company, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Management Company, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Management Company, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Management Company, LLC	100.00%	572	572	33
34	V	31	Amortization		Petersen Management Company, LLC	100.00%	2,235	2,235	34
35	V	32	Interest		Petersen Management Company, LLC	100.00%	27,638	27,638	35
36	V	33	Real Estate Taxes		Petersen Management Company, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Management Company, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Management Company, LLC	100.00%	0		38
39	Total			$			$ 42,052	$ * 42,052	39

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] 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 Management, Inc.	100.00%	$ 3,916	$ 3,916	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	6	6	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	31	31	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	225	225	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,553	1,553	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	120	120	22
23	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	17	Administrative	234,900	Petersen Health Care Management, Inc.	100.00%	56,947	(177,953)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	6,927	6,927	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	124	124	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	43,906	43,906	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	29,363	29,363	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	302	302	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	69	69	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,082	3,082	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	473	473	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	7,033	7,033	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	227	227	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	513	513	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	595	595	38
39	Total			$ 234,900			$ 155,412	$ * (79,488)	39

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] YES [ ] NO

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

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	Petersen 25, LLC	100.00%	$ 6,314	$ 6,314	15
16	V	26	Insurance-Property		Petersen 25, LLC	100.00%	20,010	20,010	16
17	V	26	Insurance-MIP		Petersen 25, LLC	100.00%	9,202	9,202	17
18	V	30	Depreciation		Petersen 25, LLC	100.00%	53,795	53,795	18
19	V	31	Amortization		Petersen 25, LLC	100.00%	3,872	3,872	19
20	V	32	Interest		Petersen 25, LLC	100.00%	47,455	47,455	20
21	V	33	Real Estate Taxes		Petersen 25, LLC	100.00%	28,552	28,552	21
22	V	34	Rent-Income and Grounds	182,411	Petersen 25, LLC			(182,411)	22
23	V								23
24	V								24
25	V								25
26	V								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			$ 182,411			$ 169,200	$ * (13,211)	39

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care \	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care \	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care \	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care \	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care X	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									$		1
2											2
3	N/A										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 # 0052308 Report Period Beginning: 1/1/2015 Ending: 2/31/2015

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,553,881	75	$ 0	$ 0	20,208	$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	20,208	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	20,208	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	20,208	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	20,208	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	20,208	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	20,208	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	20,208	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	20,208	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	20,208	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	20,208	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	20,208	197	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	20,208	53	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	20,208	0	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	0	0	20,208	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	20,208	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	20,208	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	20,208	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	20,208	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	20,208	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	20,208	766	21
22	32	Interest	Resident Days	1,553,881	75	0	0	20,208	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	20,208	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	20,208	0	24
25	TOTALS					$ 78,110	$		$ 1,016	25

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 2/31/2015

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 [X] NO [ ]

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

Name of Related Organization: Petersen Management Company, LLC
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: ((309)691-8113
Fax Number: ((309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	172,530	6	$	$	20,208	$	1
2	2	Food	Resident Days	172,530	6			20,208		2
3	3	Housekeeping	Resident Days	172,530	6			20,208		3
4	4	Laundry	Resident Days	172,530	6			20,208		4
5	5	Utilities	Resident Days	172,530	6			20,208		5
6	6	Maintenance	Resident Days	172,530	6			20,208		6
7	7	Mgmt. Allocation of Benefits	Resident Days	172,530	6			20,208		7
8	10	Nursing and Medical Records	Resident Days	172,530	6			20,208		8
9	15	Mgmt. Allocation of Benefits	Resident Days	172,530	6			20,208		9
10	17	Administrative	Resident Days	172,530	6			20,208		10
11	19	Professional Services	Resident Days	172,530	6	64,696		20,208	7,578	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	172,530	6	34,401		20,208	4,029	12
13	21	Clerical and General Office	Resident Days	172,530	6			20,208		13
14	22	Employee Benefits & Payroll	Resident Days	172,530	6			20,208		14
15	23	Inservice Training & Education	Resident Days	172,530	6			20,208		15
16	24	Travel and Seminar	Resident Days	172,530	6			20,208		16
17	25	Other Admin. Staff Transport.	Resident Days	172,530	6			20,208		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	172,530	6			20,208		18
19	30	Depreciation	Resident Days	172,530	6	4,880		20,208	572	19
20	31	Amortization	Resident Days	172,530	6	19,078		20,208	2,235	20
21	32	Interest	Resident Days	172,530	6	235,965		20,208	27,638	21
22	33	Real Estate Taxes	Resident Days	172,530	6			20,208		22
23	34	Rent-Facility and Grounds	Resident Days	172,530	6			20,208		23
24	35	Rent-Equipment & Vehicles	Resident Days	172,530	6			20,208		24
25	TOTALS					$ 359,020	$		$ 42,052	25

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 2/31/2015

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 [X] NO [ ]

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

Name of Related Organization: Petersen Health Care Management, 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,553,881	75	$ 301,135	$ 292,840	20,208	$ 3,916	1
2	2	Food	Resident Days	1,553,881	75	480		20,208	6	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,362	20,208	31	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		20,208	225	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	88,000	20,208	1,553	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			20,208		6
7	9	Medical Director	Resident Days	1,553,881	75			20,208		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192		20,208	120	8
9	10A	Therapy	Resident Days	1,553,881	75			20,208		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			20,208		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	4,755,666	20,208	56,947	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		20,208	6,927	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		20,208	124	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,043,176	20,208	43,906	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	2,257,824		20,208	29,363	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		20,208	302	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		20,208	69	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		20,208	3,082	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		20,208	473	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			20,208		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		20,208	7,033	21
22	32	Interest	Resident Days	1,553,881	75	17,439		20,208	227	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		20,208	513	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		20,208	595	24
25	TOTALS					$ 12,370,446	$ 8,182,044		$ 155,412	25

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	1st Merit		X	HUD Loan	Varies	5/1/13	1,500,000	$ 1,396,875	4/30/38	Varies	$ 47,853	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 1,500,000	$ 1,396,875			$ 47,853	9
	B. Non-Facility Related*											
10								Interest Income Offset			(449)	10
11								Home Office Allocation-PMC			27,638	11
12								Home Office Allocation-PHCM			227	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 27,416	14
15	TOTALS (line 9+line14)						$ 1,500,000	$ 1,396,875			$ 75,269	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 9,202 Line # 26

* 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 # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

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

Line	Description		Amount	Line
1	Real Estate Tax accrual used on 2014 report.	$	28,488	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.)	$	28,096	2
3	Under or (over) accrual (line 2 minus line 1).	$	(392)	3
4	Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	28,944	4
5	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Home Office Allocation** 513 **TOTAL REFUND $ ____ For ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	29,065	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

Year	Amount	Line
2010	25,924	8
2011	26,235	9
2012	27,364	10
2013	27,660	11
2014	28,096	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY

Line	Description		Amount	Line
13	FROM R. E. TAX STATEMENT FOR 2014	$		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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Casey Health Care Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0052308

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 2014 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 2014.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	03-11-17-20-403-005	Long-Term Care Facility	$ 28,096.14	$ 28,096.14
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 28,096.14	$ 28,096.14

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation 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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 96,790
2. Number of Years Over Which it is Being Amortized: 25
3. Current Period Amortization: 6,107
4. Dates Incurred: January-December 2014

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	69		2004	1972	$ 900,000	$	35	$ 25,714	$ 25,714	$ 289,283	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sidewalks			2004	4,990		15	333	333	3,689	9
10	Sidewalks			2005	4,885		15	326	326	3,423	10
11	Carpentry			2005	7,356		30	245	245	2,675	11
12	Alarm System			2005	13,492		10	901	901	13,492	12
13	A/C Unit			2006	4,978		10	498	498	4,731	13
14	Sign			2006	580		10	58	58	551	14
15	Roof Repair			2006	7,560		20	378	378	3,590	15
16	Sidewalks			2007	3,216		15	214	214	1,819	16
17	Blinds			2007	2,070		10	207	207	1,760	17
18	Smoke Detectors			2007	1,432		10	143	143	1,216	18
19	Asphalt Resurfacing			2008	48,000		15	3,200	3,200	24,000	19
20	Water Heater			2010	3,763		10	376	376	2,068	20
21	Sprinkler System			2011	92,400		25	3,696	3,696	16,632	21
22	Water Heater			2012	3,350		7	478	478	1,673	22
23	Overhang and Siding Repair			2014	7,425		7	1,061	1,061	1,591	23
24	Parking Lot Repairs			2014	5,200		7	743	743	1,114	24
25	Seal Coating of Parking Lot			2015	2,815		7	201	201	201	25
26	Roof and Siding Replacement			2015	105,631		25	2,113	2,113	2,113	26
27	Fence Around Perimeter of Facility			2015	9,874		15	329	329	329	27
28											28
29											29
30	Land Improvements Booked					4,274			(4,274)		30
31	Building Booked					36,109			(36,109)		31
32	Building Improvement Booked					10,240			(10,240)		32
33											33
34	2015-Home Office Allocation-Building Improvements				8,842			212	212		34
35	2015-Home Office Allocation-Land Improvements				825			53	53		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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,238,684	$ 50,623		$ 41,479	$ (9,145)	$ 375,950	70

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	$ 46,917	$ 3,949	$ 4,692	$ 743	5-10 yrs.	$ 29,527	71
72	Current Year Purchases	3,700	44	185	141	10 yrs.	185	72
73	Fully Depreciated Assets	180,797					180,797	73
74	Home Office Allocation			8,106	8,106			74
75	TOTALS	$ 231,414	$ 3,993	$ 12,983	$ 8,990		$ 210,509	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										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)	$ 1,505,098	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 54,616	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 54,462	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (155)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 586,459	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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 17,246 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	TOTAL		$ 571.88	$ 6,863	21

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

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

Casey Health Care Center
0052308
Period Beginning 1/1/2015
Period End 12/31/2015

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	$ 13,964
Dishwasher	182
Copier	2,505
Home Office Allocation	595
	17,246

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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.)

		1	2	3	4	5	6	7	8	
	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	$	4,627	$ 69,400	$	4,627	$ 69,400	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,155	32,324		2,155	32,324	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		8,844	132,655	313	8,844	132,968	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 prescrpts				73,659		73,659	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	TOTAL			$	15,626	$ 234,379	$ 73,972	15,626	$ 308,351	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 # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (788,798)	$ (788,798)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 159,717)	1,233,743	1,233,743	3
4	Supply Inventory (priced at Cost)	11,884	11,884	4
5	Short-Term Investments			5
6	Prepaid Insurance	20,781	26,225	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		15,105	8
9	Other(specify): Employee Loans & PPD Mgmt F	46,078	46,078	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 523,688	$ 544,237	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		35,000	13
14	Buildings, at Historical Cost		908,842	14
15	Leasehold Improvements, at Historical Cost		329,842	15
16	Equipment, at Historical Cost	9,140	231,414	16
17	Accumulated Depreciation (book methods)	(1,080)	(586,459)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		96,790	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(10,324)	20
21	Restricted Funds		419,456	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,060	$ 1,424,561	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 531,748	$ 1,968,798	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 585,427	$ 585,427	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,035	76,035	30
31	Accrued Taxes Payable (excluding real estate taxes)	182,138	182,138	31
32	Accrued Real Estate Taxes(Sch.IX-B)		28,944	32
33	Accrued Interest Payable		3,935	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	3,323	3,323	36
37	Accrued Management Fees			37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 846,923	$ 879,802	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,396,875	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	391,930	199,294	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 391,930	$ 1,596,169	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,238,853	$ 2,475,971	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (707,105)	$ (507,173)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 531,748	$ 1,968,798	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,195,165)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	1,392	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,193,773)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	486,668	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)**	$ 486,668	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)**	$ (707,105)	24 *

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,089,782	1
2	Discounts and Allowances for all Levels	(358,017)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,731,765	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	441,143	6
7	Oxygen	791	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 441,934	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	5,553	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	115,971	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,463	20
21	Other Medical Services	17,884	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 144,871	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	51	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Transportation, Misc., Meals on Wheels Revenue	9,593	28
28a	Gain on Reserve Income for Prior Year Expenses	18,685	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,278	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,346,899	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	588,088	31
32	Health Care	1,336,228	32
33	General Administration	467,832	33
	B. Capital Expense		
34	Ownership	206,746	34
	C. Ancillary Expense		
35	Special Cost Centers	113,541	35
36	Provider Participation Fee	147,796	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,860,231	40
41	**Income before Income Taxes (line 30 minus line 40)****	486,668	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 486,668	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,337,392	44
45	Private Pay - Net Inpatient Revenue	1,039,590	45
46	Medicare - Net Inpatient Revenue	327,462	46
47	Other-(specify) Insurance Net Inpatient Revenue	28,200	47
48	Other-(specify) Charity Therapy Allowance	(879)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,731,765	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** 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 # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	1,671	1,671	$ 47,691	$ 28.54	1
2	Assistant Director of Nursing	1,213	1,213	27,613	22.76	2
3	Registered Nurses	7,259	7,551	184,187	24.39	3
4	Licensed Practical Nurses	7,824	8,102	153,317	18.92	4
5	CNAs & Orderlies	41,992	43,318	463,590	10.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,974	2,174	29,340	13.50	9
10	Activity Assistants					10
11	Social Service Workers	1,755	1,808	25,532	14.12	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,004	17.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,319	9,878	97,273	9.85	15
16	Dishwashers					16
17	Maintenance Workers	1,940	2,092	38,473	18.39	17
18	Housekeepers	11,994	12,157	114,703	9.44	18
19	Laundry	5	5	43	8.60	19
20	Administrator	2,080	2,080	56,947	27.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,034	2,137	27,594	12.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,992	4,118	70,505	17.12	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	835	839	8,872	10.57	33
34	TOTAL (lines 1 - 33)	97,967	101,223	$ 1,381,684 *	$ 13.65	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	16	$ 912	L1, C3	35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,345	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)	16	$ 15,257		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	268	$ 8,168	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	268	$ 8,168		53

Casey Health Care Center
0052308
Period Beginning 1/1/2015
Period End 12/31/2015

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Transportation		617	617	6,514	10.56
Restorative Salaries		218	222	2,358	10.62
	TOTAL	835	839	8,872	

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %		Amount
Kelly Clark	Administrator	0	$	56,947
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$	56,947

B. Administrative - Other

Description		Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$	234,900
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$	234,900

C. Professional Services

Vendor/Payee	Type		Amount
Mediacom	Computer Services	$	1,631
E-Health Data Solutions	Computer Services		4,162
ProTitle USA	Legal Fees		96
Allscripts	Data Services		1,213
Medicaid	Reimb. For Copying Fees		(360)
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$	6,742

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance	$	35,464
Unemployment Compensation Insurance		38,597
FICA Taxes		97,454
Employee Health Insurance		(4,428)
Employee Meals		
Illinois Municipal Retirement Fund (IMRF)*		
Employee Relations		671
Employee Retirement		484
Home Office Allocation		29,363
TOTAL (agree to Schedule V, line 22, col.8)	$	197,605

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #		Amount
N/A			
TOTAL		$	

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee	$	1,990
Advertising: Employee Recruitment		52
Health Care Worker Background Check (Indicate # of checks performed 120)		1,669
Miscellaneous Licenses & Permits		900
Miscellaneous Dues & Subscriptions		
Home Office Allocation		4,206
Less: Public Relations Expense	(	)
Non-allowable advertising	(	)
Yellow page advertising	(	)
TOTAL (agree to Sch. V, line 20, col. 8)	$	8,817

G. Schedule of Travel and Seminar**

Description		Amount
Out-of-State Travel	$	
In-State Travel		
Seminar Expense		
Home Office Allocation		69
Entertainment Expense	(	)
TOTAL (agree to Sch. V, line 24, col. 8)	$	69

**See instructions.

Casey Health Care Center
0052308
Period Beginning **1/1/2015**
Period End **12/31/2015**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,742
Denton's US LLP	Legal	98
Applegate and Thorne	Legal	15
Miller Hall and Triggs	Legal	15
Healthcare Resources International	Legal	81
Lexis Nexis	Legal	6
GoffWilson	Legal	674
First Merit	Legal	250
CliftonLarson Allen	Accountants	1,052
Ginoli & Co.	Accountants	6,696
Miscellaneous	Computer Services	264
CCH	Computer Services	12
PTC Select	Computer Services	16
Advanced Answers on Demand	Computer Services	2157
Stratus Networks	Computer Services	392
Kemper Technology	Computer Services	577
AT&T	Computer Services	5
Ability Network	Computer Services	555
CIAN	Computer Services	391
Comcast	Computer Services	15
Emdeon	Computer Services	32
Charter Communications	Computer Services	27
Allscripts	Computer Services	469
Allpayer Exchange	Computer Services	12
E-Health Technologies	Computer Services	8
Macquarie Technology Services	Computer Services	13
Optimizer	Other Prof Fees	38

D.J. Howard Appraisers	Other Prof Fees	34
Key Corporate Services	Other Prof Fees	114
Consolidated Land Surveying	Other Prof Fees	72
Alan Litwiller	Other Prof Fees	15
Marotta Gund Budd & Derza	Other Prof Fees	6911
Total (agree to Schedule V, line 19, column 8)		27,758

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **21,822** 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **147,796**
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. $ **5,553**

(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. $ **8,116**
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. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.