

		FOR BHF USE					

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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

<p>I. IDPH License ID Number: <u>0052308</u></p> <p>Facility Name: <u>Casey Health Care Center</u></p> <p>Address: <u>100 N. E. 15th</u> <u>Casey</u> <u>62420</u> <small>Number City Zip Code</small></p> <p>County: <u>Clark</u></p> <p>Telephone Number: <u>(217) 932-5217</u> Fax # <u>(217) 932-5408</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>10/18/2004</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px; vertical-align: top;">Officer or Administrator of Provider</td> <td style="padding: 5px;"> (Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;">Paid Preparer</td> <td style="padding: 5px;"> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u> </td> </tr> </table> <p align="right"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # <u>()</u>							

Facility Name & ID Number Casey Health Care Center

0052308 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	13,011	5,674	1,798	20,483	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,011	5,674	1,798	20,483	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.33%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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

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 10/18/2004

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 1,466

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Casey Health Care Center # 0052308 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	138,465	15,016		153,481		153,481	4,598	158,079		1
2	Food Purchase		131,657		131,657		131,657	(5,839)	125,818		2
3	Housekeeping	117,582	24,570		142,152		142,152	69	142,221		3
4	Laundry		7,527	36	7,563		7,563		7,563		4
5	Heat and Other Utilities			90,914	90,914		90,914	242	91,156		5
6	Maintenance	41,045	6,226	10,267	57,538		57,538	3,407	60,945		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	297,092	184,996	101,217	583,305		583,305	2,477	585,782		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	884,720	70,077	48,704	1,003,501		1,003,501	(662)	1,002,839		10
10a	Therapy			261,383	261,383		261,383		261,383		10a
11	Activities	51,696	313	13	52,022		52,022	(12,293)	39,729		11
12	Social Services	23,211			23,211		23,211		23,211		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	959,627	70,390	322,100	1,352,117		1,352,117	(12,955)	1,339,162		16
	C. General Administration										
17	Administrative			245,600	245,600		245,600	(184,550)	61,050		17
18	Directors Fees										18
19	Professional Services			7,900	7,900		7,900	54,171	62,071		19
20	Dues, Fees, Subscriptions & Promotions			6,282	6,282		6,282	107	6,389		20
21	Clerical & General Office Expenses	30,911	4,562	9,340	44,813		44,813	52,695	97,508		21
22	Employee Benefits & Payroll Taxes			143,633	143,633		143,633	22,261	165,894		22
23	Inservice Training & Education			(113)	(113)		(113)	137	24		23
24	Travel and Seminar							68	68		24
25	Other Admin. Staff Transportation			5,387	5,387		5,387	3,295	8,682		25
26	Insurance-Prop.Liab.Malpractice			2,150	2,150		2,150	30,626	32,776		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	30,911	4,562	420,179	455,652		455,652	(21,190)	434,462		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,287,630	259,948	843,496	2,391,074		2,391,074	(31,668)	2,359,406		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:

1/1/2017

Ending:

12/31/2017

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			1,039	1,039		1,039	67,894	68,933			30
31	Amortization of Pre-Op. & Org.							3,978	3,978			31
32	Interest							75,170	75,170			32
33	Real Estate Taxes							30,830	30,830			33
34	Rent-Facility & Grounds			184,132	184,132		184,132	(184,132)				34
35	Rent-Equipment & Vehicles			12,754	12,754		12,754	1,397	14,151			35
36	Other (specify):*											36
37	TOTAL Ownership			197,925	197,925		197,925	(4,863)	193,062			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		52,934		52,934		52,934		52,934			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			151,604	151,604		151,604		151,604			42
43	Other (specify):*		616	45,749	46,365		46,365	(46,365)				43
44	TOTAL Special Cost Centers		53,550	197,353	250,903		250,903	(46,365)	204,538			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,287,630	313,498	1,238,774	2,839,902		2,839,902	(82,896)	2,757,006			45

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

Casey Health Care Center

ID# 0052308

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,927)	43	1
2	X-Rays-Part A	(1,726)	43	2
3	Offset Transportation Revenue	(12,293)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(105)	21	4
5	Disallowed Special Events	1,651	43	5
6	Disallowed Meals on Wheels Revenue	(1,059)	2	6
7	Offset Miscellaneous Nursing Supplies Revenue	(726)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
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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	(17,185)		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 Management, Inc.	100.00%	\$ 4,598	\$ 4,598	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	20	20	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	69	69	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	242	242	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	2,173	2,173	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	64	64	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	245,600	Petersen Health Care Management, Inc.	100.00%	61,050	(184,550)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	14,401	14,401	12
13	V							13
14	Total		\$ 245,600			\$ 82,617	\$ * (162,983)	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 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 107	\$	107	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	49,490		49,490	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	22,261		22,261	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	137		137	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	68		68	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	3,295		3,295	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	873		873	21
22	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	11,786		11,786	22
23	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	106		106	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	383		383	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	264		264	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,397		1,397	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		\$			\$ 90,167	\$ *	90,167	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 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%	34,280	34,280	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Management Company, LLC	100.00%	0		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%	1,615	1,615	33
34	V	31 Amortization		Petersen Management Company, LLC	100.00%	0		34
35	V	32 Interest		Petersen Management Company, LLC	100.00%	30,073	30,073	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		\$			\$ 65,968	\$ * 65,968	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	6 Maintenance	\$	Petersen 25, LLC	100.00%	\$ 1,234	\$ 1,234
16	V	19 Professional Services		Petersen 25, LLC	100.00%	5,490	5,490
17	V	21 Equipment		Petersen 25, LLC	100.00%	3,310	3,310
18	V	26 Insurance-Property		Petersen 25, LLC	100.00%	21,104	21,104
19	V	26 Insurance-Mortgage Insurance		Petersen 25, LLC	100.00%	8,649	8,649
20	V	30 Depreciation		Petersen 25, LLC	100.00%	65,670	65,670
21	V	31 Amortization		Petersen 25, LLC	100.00%	3,872	3,872
22	V	32 Interest	269	Petersen 25, LLC	100.00%	44,983	44,714
23	V	33 Real Estate Taxes		Petersen 25, LLC	100.00%	30,566	30,566
24	V	34 Rent-Income and Grounds	184,132	Petersen 25, LLC	100.00%		(184,132)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 184,401			\$ 184,878	\$ * 477

* 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:

1/1/2017

Ending: 12/31/2017

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 System	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	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busine	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	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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

Facility Name & ID Number

Casey Health Care Center

0052308

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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

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:

1/1/2017

Ending:

12/31/2017

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											2
3											3
4	N/A										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:

1/1/2017

Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization Petersen Health Care 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,451,714	75	\$ 325,901	\$ 376,129	20,483	\$ 4,598	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	20,483	20	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	20,483	69	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	20,483	242	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	20,483	2,173	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	20,483	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	20,483	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	20,483	64	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	20,483	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	20,483	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	20,483	61,050	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	20,483	14,401	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	20,483	107	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	20,483	49,490	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	20,483	22,261	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	20,483	137	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	20,483	68	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	20,483	3,295	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	20,483	873	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	835,302	0	20,483	11,786	20
21	30	Depreciation	Resident Days	1,451,714	75	7,526	0	20,483	106	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	20,483	383	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	20,483	264	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	20,483	1,397	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 172,784	25

Facility Name & ID Number Casey Health Care Center

0052308

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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 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	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	161,351	9	\$	\$	20,483	\$	1
2	2	Food	Resident Days	161,351	9			20,483		2
3	3	Housekeeping	Resident Days	161,351	9			20,483		3
4	4	Laundry	Resident Days	161,351	9			20,483		4
5	5	Utilities	Resident Days	161,351	9			20,483		5
6	6	Maintenance	Resident Days	161,351	9			20,483		6
7	7	Mgmt. Allocation of Benefits	Resident Days	161,351	9			20,483		7
8	10	Nursing and Medical Records	Resident Days	161,351	9			20,483		8
9	15	Mgmt. Allocation of Benefits	Resident Days	161,351	9			20,483		9
10	17	Administrative	Resident Days	161,351	9			20,483		10
11	19	Professional Services	Resident Days	161,351	9	270,032		20,483	34,280	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	161,351	9			20,483		12
13	21	Clerical and General Office	Resident Days	161,351	9			20,483		13
14	22	Employee Benefits & Payroll	Resident Days	161,351	9			20,483		14
15	23	Inservice Training & Education	Resident Days	161,351	9			20,483		15
16	24	Travel and Seminar	Resident Days	161,351	9			20,483		16
17	25	Other Admin. Staff Transport.	Resident Days	161,351	9			20,483		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	161,351	9			20,483		18
19	30	Depreciation	Resident Days	161,351	9	12,723		20,483	1,615	19
20	31	Amortization	Resident Days	161,351	9			20,483		20
21	32	Interest	Resident Days	161,351	9	236,896		20,483	30,073	21
22	33	Real Estate Taxes	Resident Days	161,351	9			20,483		22
23	34	Rent-Facility and Grounds	Resident Days	161,351	9			20,483		23
24	35	Rent-Equipment & Vehicles	Resident Days	161,351	9			20,483		24
25	TOTALS					\$ 519,651	\$		\$ 65,968	25

Facility Name & ID Number

Casey Health Care Center

0052308

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	1st Merit		X	HUD Loan	Varies	5/1/13	1,500,000	\$ 1,310,627	4/30/38	Varies	\$ 44,983	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 1,500,000	\$ 1,310,627			\$ 44,983	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(269)	10						
11									Home Office Allocation-PMC		30,073	11						
12									Home Office Allocation-PHCM		383	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 30,187	14						
15	TOTALS (line 9+line14)						\$ 1,500,000	\$ 1,310,627			\$ 75,170	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 8,649 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.		\$	29,412	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.)		\$	29,546	2
3. Under or (over) accrual (line 2 minus line 1).		\$	134	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	30,432	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. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	Home Office Allocation 264	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	30,830	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	27,364	8
	2013	27,660	9
	2014	28,096	10
	2015	28,554	11
	2016	29,546	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

2016 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 MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>03-11-17-20-403-005</u>	<u>Long-Term Care Facility</u>	\$ <u>29,546.28</u>	\$ <u>29,546.28</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ <u><u>29,546.28</u></u>	\$ <u><u>29,546.28</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 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Casey Health Care Center

0052308 Report Period Beginning:

1/1/2017 Ending:

12/31/2017

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? (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: 96,790 2. Number of Years Over Which it is Being Amortized: 25
 3. Current Period Amortization: 3,978 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	225,000	2004	\$ 35,000	1
2					2
3	TOTALS	225,000		\$ 35,000	3

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	\$ 34,053	\$ 340,711	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Alarm System		2005	13,492		10			13,492	9
10	A/C Unit		2006	4,978		10			4,978	10
11	Roof Repair		2006	7,560		20	378	378	4,346	11
12	Sidewalks		2007	3,216		15	214	214	2,247	12
13	Asphalt Resurfacing		2008	48,000		15	3,200	3,200	30,400	13
14	Water Heater		2010	3,763		10	376	376	2,820	14
15	Sprinkler System		2011	92,400		25	3,696	3,696	24,024	15
16	Overhang and Siding Repair		2014	7,425		7	1,061	1,061	3,713	16
17	Parking Lot Repairs		2014	5,200		7	743	743	2,600	17
18	Seal Coating of Parking Lot		2015	2,815		7	402	402	1,005	18
19	Roof and Siding Replacement		2015	105,631		25	4,226	4,226	10,565	19
20	Fence Around Perimeter of Facility		2015	9,874		15	658	658	1,645	20
21	Ceramic Tile Replace-Office, Commons, Dining Room, 38 Rooms		2016	145,748		15	9,716	9,716	14,574	21
22	Water Heater		2016	4,054		7	580	580	870	22
23	Air Conditioner		2016	6,800		15	454	454	681	23
24	Water Heater		2017	4,346		7	310	310	310	24
25										25
26										26
27										27
28										28
29										29
30	Land Improvements Booked				4,475			(4,475)		30
31	Building Booked				36,109			(36,109)		31
32	Building Improvement Booked				22,865			(22,865)		32
33										33
34	2017-Home Office Allocation-Building Improvements			9,369			225	225		34
35	2017-Home Office Allocation-Land Improvements			862			56	56		35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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	TOTAL (lines 4 thru 69)	\$ 1,375,533	\$ 63,449		\$ 52,009	\$ (3,101)	\$ 458,981	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:

1/1/2017

Ending:

12/31/2017

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	\$ 40,268	\$ 3,189	\$ 3,590	\$ 401	5-10 yrs.	\$ 27,687	71
72	Current Year Purchases	2,991	71	214	143	7 yrs.	214	72
73	Fully Depreciated Assets	191,147					191,147	73
74	Home Office Allocation			13,120	13,120			74
75	TOTALS	\$ 234,406	\$ 3,260	\$ 16,924	\$ 13,664		\$ 219,048	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)	\$ 1,644,939	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 66,709	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 68,933	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,224	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 678,029	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					88
89	N/A				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

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. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,576 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	<u>Facility</u>	<u>Ford E-150 Van</u>	\$ <u>571.88</u>	\$ <u>4,575</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>571.88</u>	\$ <u>4,575</u>	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 1/1/2017

Period End 12/31/2017

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	4,430
Dishwasher		1,084
Copier		2,665
Home Office Allocation		1,397
		<u>9,576</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,990	\$ 104,843	\$	6,990	\$ 104,843	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,737	41,055		2,737	41,055	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		7,699	115,369		7,699	115,369	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				52,934		52,934	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Respiratory Therapy</u>	10A(3)			8	116		8	116	12
13	Other (specify):									13
14	TOTAL			\$	17,434	\$ 261,383	\$ 52,934	17,434	\$ 314,317	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: 1/1/2017

Ending:

12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(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	\$ (177,438)	\$ (177,438)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 118,954)	1,782,308	1,782,308	3
4	Supply Inventory (priced at Cost)	11,884	11,884	4
5	Short-Term Investments			5
6	Prepaid Insurance	13,422	18,726	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)		15,248	8
9	Other(specify): <u>PPD Mgmt Fees</u>	106,114	106,114	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,736,290	\$ 1,756,842	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		909,369	14
15	Leasehold Improvements, at Historical Cost		466,164	15
16	Equipment, at Historical Cost	12,132	234,406	16
17	Accumulated Depreciation (book methods)	(3,763)	(678,029)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		96,790	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(18,067)	20
21	Restricted Funds		299,385	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>		15	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,369	\$ 1,345,033	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,744,659	\$ 3,101,875	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 628,535	\$ 723,789	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,058	76,058	30
31	Accrued Taxes Payable (excluding real estate taxes)	122,120	122,120	31
32	Accrued Real Estate Taxes(Sch.IX-B)		30,432	32
33	Accrued Interest Payable		3,692	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	968	968	36
37	<u>Accrued Management Fees</u>	13,404	13,404	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 841,085	\$ 970,463	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		1,310,627	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	391,930	88,055	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 391,930	\$ 1,398,682	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,233,015	\$ 2,369,145	46
47	TOTAL EQUITY (page 18, line 24)	\$ 511,644	\$ 732,730	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,744,659	\$ 3,101,875	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (151,788)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Report Was Filed	8,586	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (143,202)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	654,846	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)	\$ 654,846	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)	\$ 511,644	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Casey Health Care Center

0052308

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,135,931	1
2	Discounts and Allowances for all Levels	(255,677)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,880,254	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	492,845	6
7	Oxygen	3,360	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 496,205	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	5,859	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	83,081	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,314	20
21	Other Medical Services	10,911	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 105,165	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	12,293	28
28a	<u>Miscellaneous Revenue</u>	831	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,124	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,494,748	30

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	583,305	31
32	Health Care	1,352,117	32
33	General Administration	455,652	33
B. Capital Expense			
34	Ownership	197,925	34
C. Ancillary Expense			
35	Special Cost Centers	99,299	35
36	Provider Participation Fee	151,604	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,839,902	40
41	Income before Income Taxes (line 30 minus line 40)**	654,846	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 654,846	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,704,392	44
45	Private Pay - Net Inpatient Revenue	817,929	45
46	Medicare - Net Inpatient Revenue	267,335	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	90,598	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,880,254	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:

1/1/2017

Ending:

12/31/2017

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	1,915	1,915	\$ 53,118	\$ 27.74	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,317	2,440	72,625	29.76	3
4	Licensed Practical Nurses	11,689	12,090	234,829	19.42	4
5	CNAs & Orderlies	38,444	39,545	459,828	11.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,918	2,158	29,191	13.53	9
10	Activity Assistants					10
11	Social Service Workers	1,881	1,950	23,211	11.90	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,735	18.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,240	9,781	100,730	10.30	15
16	Dishwashers					16
17	Maintenance Workers	1,929	2,105	41,045	19.50	17
18	Housekeepers	11,690	12,110	117,582	9.71	18
19	Laundry					19
20	Administrator	2,080	2,080	61,050	29.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,160	2,249	30,911	13.74	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Page 20A</u>	5,172	5,254	86,825	16.53	33
34	TOTAL (lines 1 - 33)	92,515	95,757	\$ 1,348,680 *	\$ 14.08	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	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,470	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)		\$ 17,470		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,355	\$ 41,942	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,355	\$ 41,942		53

Casey Health Care Center

0052308

Period Beginning 1/1/2017

Period End 12/31/2017

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	2,128	2,128	51,877	24.38
Restorative Nurse	1,044	1,046	12,443	11.90
Transportation	2,000	2,080	22,505	10.82
TOTAL	5,172	5,254	86,825	

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	\$ 61,050	Workers' Compensation Insurance	\$ 25,018	IDPH License Fee	\$ 3,980	
				Unemployment Compensation Insurance	18,622	Advertising: Employee Recruitment	54	
				FICA Taxes	96,805	Health Care Worker Background Check (Indicate # of checks performed <u>127</u>)	1,063	
				Employee Health Insurance	1,703	Miscellaneous Licenses & Permits	233	
				Employee Meals		Miscellaneous Dues & Subscriptions	952	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	107	
				Employee Relations	949			
				Employee Retirement	536			
				Home Office Allocation	22,261			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 61,050	TOTAL (agree to Schedule V, line 22, col.8)		\$ 6,389		
B. Administrative - Other							Less: Public Relations Expense ()	
Description			Amount				Non-allowable advertising ()	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 245,600				Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 245,600				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Mediacom	Computer Services		\$ 1,636				Out-of-State Travel	\$
Ability Network	Computer Services		4,567					
Allscripts	Data Services		888				In-State Travel	
ProTitle USA	Legal Fees		150	N/A				
Honkamp Krueger	Legal Fees		659				Seminar Expense	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,900	TOTAL		\$	Home Office Allocation	68
							Entertainment Expense ()	
							TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 68	

* Attach copy of IMRF notifications

**See instructions.

Casey Health Care Center**0052308****Period Beginning****1/1/2017****Period End****12/31/2017****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,900
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	164
Arnstein & Lehr	Legal	1106
SB2	Legal	695
Miscellaneous	Legal	13
Miller Hall and Triggs	Legal	176
Smith Amundsen	Legal	68
Healthcare Resources International	Legal	122
Hunziker Law	Legal	1
Lexis Nexis	Legal	7
Baker Tilly Virchow Krause	Legal	617
Huntington Bank	Legal	5490
CliftonLarsonAllen	Accounting	2653
Ginoli & Co.	Accounting	388
Baker Tilly Virchow Krause	Accounting	123
Miscellaneous	Computer Services	93
Change Healthcare	Computer Services	8
360 Networks	Computer Services	38
Matrix Care	Computer Services	3446
Stratus Networks	Computer Services	412
Kemper Technology	Computer Services	234
AT&T	Computer Services	6
Ability Network	Computer Services	254
CIAN	Computer Services	287
Comcast	Computer Services	16
CCH	Computer Services	14
Charter Communications	Computer Services	29
Allscripts	Computer Services	255
ATS	Computer Services	262
Citrix Systems	Computer Services	24
Optimizer	Other Prof Fees	46
Ankura	Other Prof Fees	742
David Budde	Other Prof Fees	35
Sargent Consulting	Other Prof Fees	14757
Alix Partners	Other Prof Fees	21409
Demonica Kemper	Other Prof Fees	31
Brad Barkley	Other Prof Fees	121
MPAC Healthcare	Other Prof Fees	18
Higgs Appraisal	Other Prof Fees	8
Alan Litwiller	Other Prof Fees	3
Total (agree to Schedule V, line 19, column 8)		<u><u>62,071</u></u>

Facility Name & ID Number Casey Health Care Center# 0052308

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 26,066 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. \$ 151,604
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. \$ 4,800
- (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. \$ 12,293
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? Yes
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 and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted 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. No
Attach invoices and a summary of services for all architect and appraisal fees