FOR BHF USE

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2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0046243

Facility Name: Royal Oaks Care Center

Address: 605 East Church Street (Number) Kewanee (City) 61443 (Zip Code)

County: Henry

Telephone Number: (309) 852-3389 Fax # (309) 853-1838

HFS ID Number:

Date of Initial License for Current Owners: 03/01/2003

Type of Ownership:

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

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 689-5869
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 1/1/2011 to 12/31/2011 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 Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,000	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	200	TOTALS	200	73,000	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	44,338	4,184	1,671	50,193	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,338	4,184	1,671	50,193	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.76%

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)
None

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 [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 3/1/2003

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/1/2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 200 and days of care provided 1,503

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

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

Facility Name & ID Number: Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	224,947	34,468		259,415		259,415	10,126	269,541			1
2	Food Purchase		308,743		308,743		308,743	(3,610)	305,133			2
3	Housekeeping	155,895	45,170		201,065		201,065	66	201,131			3
4	Laundry	101,252	20,266		121,518		121,518		121,518			4
5	Heat and Other Utilities			202,456	202,456		202,456	662	203,118			5
6	Maintenance	59,830	16,283	32,838	108,951		108,951	7,582	116,533			6
7	Other (specify):* Home Off. Ben. All.							2,309	2,309			7
8	**TOTAL General Services**	541,924	424,930	235,294	1,202,148		1,202,148	17,135	1,219,283			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,884,735	114,510	252,479	2,251,724		2,251,724	102	2,251,826			10
10a	Therapy	25,698		289,757	315,455		315,455		315,455			10a
11	Activities	93,082	265	138	93,485		93,485	(11,206)	82,279			11
12	Social Services	116,515			116,515		116,515		116,515			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	2,120,030	114,775	554,374	2,789,179		2,789,179	(11,104)	2,778,075			16
	C. General Administration											
17	Administrative			310,000	310,000		310,000	(248,000)	62,000			17
18	Directors Fees											18
19	Professional Services			15,617	15,617		15,617	18,986	34,603			19
20	Dues, Fees, Subscriptions & Promotions			5,760	5,760		5,760	803	6,563			20
21	Clerical & General Office Expenses	76,947	6,013	13,066	96,026		96,026	105,824	201,850			21
22	Employee Benefits & Payroll Taxes			358,811	358,811		358,811		358,811			22
23	Inservice Training & Education			689	689		689	338	1,027			23
24	Travel and Seminar							99	99			24
25	Other Admin. Staff Transportation			21,557	21,557		21,557	17,929	39,486			25
26	Insurance-Prop.Liab.Malpractice			68,743	68,743		68,743	2,348	71,091			26
27	Other (specify):* Home Off. Ben. All.							38,368	38,368			27
28	**TOTAL General Administration**	76,947	6,013	794,243	877,203		877,203	(63,305)	813,898			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,738,901	545,718	1,583,911	4,868,530		4,868,530	(57,274)	4,811,256			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.

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			73,696	73,696		73,696	56,870	130,566			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			133,209	133,209		133,209	100,434	233,643			32
33	Real Estate Taxes			72,112	72,112		72,112	834	72,946			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,937	16,937		16,937	1,485	18,422			35
36	Other (specify):*											36
37	TOTAL Ownership			295,954	295,954		295,954	159,623	455,577			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,907		81,907		81,907		81,907			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* Non-allowable Costs	12,957	969	181,500	195,426		195,426	(195,426)				43
44	TOTAL Special Cost Centers	12,957	82,876	291,000	386,833		386,833	(195,426)	191,407			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,751,858	628,594	2,170,865	5,551,317		5,551,317	(93,077)	5,458,240			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 Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	(3,657)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,218)	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	7,398	30		9
10	Interest and Other Investment Income	(153)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(238)	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	(1,064)	43		18
19	Entertainment				19
20	Contributions	(200)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(175,494)	43		24
25	Fund Raising, Advertising and Promotional	(14,810)	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	(17,865)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (207,301)		$	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)	114,224	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 114,224		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (93,077)		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

Royal Oaks Care Center

ID# 0046243

Report Period Beginning: 1/1/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (3,255)	43	1
2	X-Rays-Part A	1,067	43	2
3	Disallowed Special Events	44	43	3
4	Offset Transportation Revenue	(11,206)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(3,707)	21	5
6	Offset Chamber of Commerce Dues	(550)	20	6
7	Resident Flowers	(258)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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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**	(17,865)		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. [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%	$ 10,126	$ 10,126	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	47	47	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	66	66	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	662	662	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	4,129	4,129	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,309	2,309	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	102	102	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	310,000	Petersen Health Care, Inc.	100.00%	62,000	(248,000)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	11,584	11,584	12
13	V								13
14	Total			$ 310,000			$ 91,025	$ * (218,975)	14

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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%	$ 814	$ 814	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	94,396	94,396	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	338	338	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	99	99	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	8,675	8,675	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	2,348	2,348	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	38,368	38,368	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	13,563	13,563	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	16,325	16,325	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	834	834	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	1,479	1,479	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			$			$ 177,239	$ * 177,239	39

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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 II, Inc.	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4	Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5	Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care II, Inc.	100.00%	3,453	3,453	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	12	Social Services		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17	Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19	Professional Services		Petersen Health Care II, Inc.	100.00%	7,402	7,402	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	539	539	26
27	V	21	Clerical and General Office		Petersen Health Care II, Inc.	100.00%	15,135	15,135	27
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	9,254	9,254	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30	Depreciation		Petersen Health Care II, Inc.	100.00%	35,909	35,909	34
35	V	32	Interest		Petersen Health Care II, Inc.	100.00%	84,262	84,262	35
36	V	33	Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	6	6	38
39	Total			$			$ 155,960	$ * 155,960	39

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	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 Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	1,542,131	77	$ 311,109	$ 308,619	50,193	$ 10,126	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	50,193	47	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	50,193	66	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	50,193	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	50,193	662	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	50,193	4,129	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	50,193	2,309	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	50,193	102	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	50,193	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	50,193	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	50,193	62,000	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	50,193	11,584	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	50,193	814	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	50,193	94,396	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	50,193	338	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	50,193	99	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	50,193	8,675	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	50,193	2,348	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	50,193	38,368	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	50,193	13,563	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	50,193	16,325	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	50,193	834	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	50,193	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	50,193	1,479	24
25	TOTALS					$ 11,242,734	$ 7,781,943		$ 268,264	25

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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	325,902	13	$	$	50,193	$	1
2	2	Food	Resident Days	325,902	13			50,193		2
3	3	Housekeeping	Resident Days	325,902	13			50,193		3
4	4	Laundry	Resident Days	325,902	13			50,193		4
5	5	Utilities	Resident Days	325,902	13			50,193		5
6	6	Maintenance	Resident Days	325,902	13	22,420		50,193	3,453	6
7	7	Mgmt. Allocation of Benefits	Resident Days	325,902	13			50,193		7
8	10	Nursing and Medical Records	Resident Days	325,902	13			50,193		8
9	15	Mgmt. Allocation of Benefits	Resident Days	325,902	13			50,193		9
10	17	Administrative	Resident Days	325,902	13			50,193		10
11	19	Professional Services	Resident Days	325,902	13	48,058		50,193	7,402	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	325,902	13	3,502		50,193	539	12
13	21	Clerical and General Office	Resident Days	325,902	13	98,273		50,193	15,135	13
14	22	Employee Benefits & Payroll	Resident Days	325,902	13			50,193		14
15	23	Inservice Training & Education	Resident Days	325,902	13			50,193		15
16	24	Travel and Seminar	Resident Days	325,902	13			50,193		16
17	25	Other Admin. Staff Transport.	Resident Days	325,902	13	60,087		50,193	9,254	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	325,902	13			50,193		18
19	27	Mgmt. Allocation of Benefits	Resident Days	325,902	13			50,193		19
20	30	Depreciation	Resident Days	325,902	13	233,155		50,193	35,909	20
21	32	Interest	Resident Days	325,902	13	547,113		50,193	84,262	21
22	33	Real Estate Taxes	Resident Days	325,902	13			50,193		22
23	34	Rent-Facility and Grounds	Resident Days	325,902	13			50,193		23
24	35	Rent-Equipment & Vehicles	Resident Days	325,902	13	36		50,193	6	24
25	TOTALS					$ 1,012,644	$		$ 155,960	25

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	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	U S Bank		X	Mortgage	Varies	08/31/02	$ 2,420,000	$ 1,925,812	12/31/11	Varies	$ 133,209	1
2												2
3								Interest Income Offset			(153)	3
4								Home Office Allocation-PHC			16,325	4
5								Home Office Allocation-PHC II			84,262	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,420,000	$ 1,925,812			$ 233,643	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,420,000	$ 1,925,812			$ 233,643	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

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

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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.

Item			Amount	Line
1. Real Estate Tax accrual used on 2010 report.			$ 65,880	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2010	$ 67,972	2
3. Under or (over) accrual (line 2 minus line 1).			$ 2,092	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)			$ 70,020	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		834 $	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			$ 72,946	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2006	64,060	8
2007	69,349	9
2008	67,577	10
2009	63,922	11
2010	67,972	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Royal Oaks Care Center COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0046243

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

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

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	25-03-401-008	Long-Term Care Facility	$ 66,851.18	$ 66,851.18
2.	25-03-401-009	Long-Term Care Facility	$ 1,120.48	$ 1,120.48
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 67,971.66	$ 67,971.66

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,875 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? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	362,419	2003	$ 200,000	1
2					2
3	TOTALS	362,419		$ 200,000	3

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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	200		2003	1998	$ 1,490,095	$	39	$ 38,208	$ 38,208	$ 335,099	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Architectural Fees			2003	2,010		15	134	134	1,013	9
10	Water Softener			2003	14,625		7	767	767	14,625	10
11	Disposer			2003	1,231		7	74	74	1,231	11
12	Hot Water Heater			2003	5,892		7	503	503	5,892	12
13	Parking lot			2004	25,762		15	1,717	1,717	14,596	13
14	Service Road			2004	6,940		15	463	463	3,356	14
15	Sidewalk			2004	2,600		15	173	173	1,240	15
16	Air Conditioning			2004	5,101		25	204	204	1,455	16
17	Fire Alarm			2004	5,810		25	232	232	1,655	17
18	Security System			2004	1,206		7	165	165	1,206	18
19	Water Heater			2005	6,518		30	217	217	1,374	19
20	New Flooring			2005	5,440		10	544	544	3,309	20
21	New Roof			2005	22,002		30	733	733	4,398	21
22	New Heating and Air conditioning			2006	6,378		15	425	425	2,550	22
23	Driveway			2007	7,625		15	508	508	2,296	23
24	Sidewalk			2007	7,200		15	480	480	2,160	24
25	Fire Alarm			2007	1,398		10	140	140	630	25
26	Smoke Detectors			2007	4,400		10	440	440	1,980	26
27	Water Heater			2007	11,619		10	1,162	1,162	5,229	27
28	Water Storage Tank			2008	5,647		5	1,130	1,130	3,955	28
29	Rooftop Heating Unit			2008	27,573		5	5,514	5,514	19,299	29
30	Roof			2008	72,265		39	1,852	1,852	6,482	30
31	Roof Repairs			2008	5,673		39	146	146	511	31
32	Water Heater			2009	3,240		5	648	648	1,620	32
33	Rooftop Cooling Unit			2009	13,500		5	2,700	2,700	6,750	33
34	Boiler			2010	9,033		15	602	602	903	34
35	Hot Water Heater			2010	2,998		7	428	428	642	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 Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 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	Roof Repairs	2010	$ 13,359	$	7	$ 1,908	$ 1,908	$ 2,862	37
38	Water Heater	2010	6,120		10	612	612	918	38
39	Water Pipe Repair	2011	5,544		7	396	396	396	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	Land Improvements Booked			4,358			(4,358)		60
61	Building Booked			38,229			(38,229)		61
62	Building Improvement Booked			20,298			(20,298)		62
63									63
64									64
65	2011-Home Office Allocation-Land Improvements		23,889			573	573		65
66	2011-Home Office Allocation-Building Improvements		2,230			143	143		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,824,923	$ 62,885		$ 63,941	$ 1,056	$ 449,632	70

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 622,048	$ 10,811	$ 17,153	$ 6,342	7-10 yrs.	$ 580,699	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			49,472	49,472			74
75	TOTALS	$ 622,048	$ 10,811	$ 66,625	$ 55,814		$ 580,699	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	Facility Use	2003 Ford Van	2003	$ 31,033	$	$	$		$ 31,033	76
77										77
78										78
79										79
80	TOTALS			$ 31,033	$	$	$		$ 31,033	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)	$ 2,678,004	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 73,696	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 130,566	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 56,870	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,061,364	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

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: $ 18,422 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			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	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.

Royal Oaks Care Center
0046243
Period Beginning **1/1/2011**
Period End **12/31/2011**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	11,214
Dishwasher		900
Laundry Equipment		-
Copier		4,823
Home Office Allocation		1,485
		18,422

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

It is the policy of this facility to only hire certified nurses aides.

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

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	$	8,147	$ 122,200	$	8,147	$ 122,200	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,496	22,047		1,496	22,047	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs		9,671	145,070		9,671	145,070	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				81,907		81,907	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy				29	440		29	440	13
14	TOTAL			$	19,343	$ 289,757	$ 81,907	19,343	$ 371,664	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 Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,638,183	$ 4,638,183	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 205,000)	1,824,833	1,824,833	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,447	56,447	6
7	Other Prepaid Expenses	25,167	25,167	7
8	Accounts Receivable (owners or related parties)	807	807	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,545,437	$ 6,545,437	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	250,128	200,000	13
14	Buildings, at Historical Cost	1,490,095	1,513,984	14
15	Leasehold Improvements, at Historical Cost	229,250	310,939	15
16	Equipment, at Historical Cost	676,035	653,081	16
17	Accumulated Depreciation (book methods)	(1,069,631)	(1,061,364)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,575,877	$ 1,616,640	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,121,314	$ 8,162,077	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,170,993	$ 1,170,993	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	168,077	168,077	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,470	9,470	31
32	Accrued Real Estate Taxes(Sch.IX-B)	70,020	70,020	32
33	Accrued Interest Payable	4,594	4,594	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	133,502	133,502	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,556,656	$ 1,556,656	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,925,812	1,925,812	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P-C.N.A. Insurance	96,027	96,027	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,021,839	$ 2,021,839	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,578,495	$ 3,578,495	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,542,819	$ 4,583,582	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,121,314	$ 8,162,077	48

*(See instructions.)

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,215,408	1
2	Restatements (describe):		2
3	Rounding	(3)	3
4	2010 Bad Debt Allowance Increase Entered After CR		4
5	was compeleted	5,000	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,220,405	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	322,414	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)**	$ 322,414	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)**	$ 4,542,819	24 *

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,456,296	1
2	Discounts and Allowances for all Levels	(206,391)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,249,905	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	452,393	6
7	Oxygen	427	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 452,820	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	3,657	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	129,476	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	20,529	20
21	Other Medical Services	2,278	21
22	Laundry	1,788	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 157,728	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	153	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 153	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Revenue	3,707	28
28a	Transportation Revenue	9,418	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,125	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,873,731	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,202,148	31
32	Health Care	2,789,179	32
33	General Administration	877,203	33
	B. Capital Expense		
34	Ownership	295,954	34
	C. Ancillary Expense		
35	Special Cost Centers	277,333	35
36	Provider Participation Fee	109,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,551,317	40
41	**Income before Income Taxes (line 30 minus line 40)****	322,414	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 322,414	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is part of larger entity.

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

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 67,507	$ 32.46	1
2	Assistant Director of Nursing	656	656	11,357	17.31	2
3	Registered Nurses	4,169	4,417	99,829	22.60	3
4	Licensed Practical Nurses	30,019	31,309	574,314	18.34	4
5	CNAs & Orderlies	98,153	101,547	977,733	9.63	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,025	2,185	25,698	11.76	8
9	Activity Director	827	827	8,292	10.03	9
10	Activity Assistants	3,734	3,734	36,843	9.87	10
11	Social Service Workers	9,470	9,886	116,515	11.79	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,607	13.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,675	23,188	197,340	8.51	15
16	Dishwashers					16
17	Maintenance Workers	4,009	4,123	59,830	14.51	17
18	Housekeepers	17,714	18,662	155,895	8.35	18
19	Laundry	10,678	11,091	101,252	9.13	19
20	Administrator	2,080	2,080	62,000	29.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,940	5,072	76,947	15.17	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	2,398	2,446	30,657	12.53	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	10,941	11,448	184,242	16.09	33
34	TOTAL (lines 1 - 33)	228,648	236,831	$ 2,813,858 *	$ 11.88	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 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	9,095	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)		$ 21,095		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,260	$ 104,283	L10, C3	50
51	Licensed Practical Nurses	4,362	138,236	L10, C3	51
52	Certified Nurse Assistants/Aides			L10, C3	52
53	TOTAL (lines 50 - 52)	7,622	$ 242,519		53

Royal Oaks Care Center

Period Beginning **1/1/2011**
Period End **12/31/2011**

<u>Schedule 20A</u>

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	5,870	5,990	123,338	20.59
Transportation	3,991	4,331	47,947	11.07
Marketing	1,080	1,127	12,957	11.50
TOTAL	10,941	11,448	184,242	

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Angela Ince	Administrator	0	$ 62,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 62,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 310,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 310,000

C. Professional Services

Vendor/Payee	Type	Amount
Henry County Recorder	Recording Fee	$ 82
E-Health Data Solutions	Computer Services	4,985
Comcast	Computer Services	1,456
Esquire Solutions	Legal Services	572
Heyl, Royster, Voelker & Allen	Legal Services	379
Teleen, Horborg, & Smith	Legal Services	7,906
Honkamp, Kruger and Co.	Accounting Fees	237
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 15,617

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,336
Unemployment Compensation Insurance	45,261
FICA Taxes	207,380
Employee Health Insurance	44,448
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	300
Employee Retirement	1,086
TOTAL (agree to Schedule V, line 22, col.8)	$ 358,811

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		436
Health Care Worker Background Check		
(Indicate # of checks performed)		
Patient Background Checks	215	2,154
Miscellaneous Licenses & Permits		630
Miscellaneous Dues & Subscriptions		550
Home Office Allocation		1,353
Less: Public Relations Expense		(550)
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 6,563

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	99
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 99

**See instructions.

Royal Oaks Care Center
0046243
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		15,617
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	12
Henry County Recorder	Legal	1
Ginoli & Company	Accountants	1,609
Miscellaneous Vendors	Computer Services	129
Advanced Answers on Demand	Computer Services	6,719
Access 2 Go	Computer Services	661
Kemper Technology	Computer Services	308
MediFax	Computer Services	104
VisionShare/Ability Network	Computer Services	473
Advanced System Design	Computer Services	619
Simple LTC	Computer Services	777
Optimizer Systems	Other Prof Fees	79
Clifton Gunderson	Other Prof Fees	27
Mike Miller	Other Prof Fees	38
OIC Group	Other Prof Fees	9
AllScripts	Other Prof Fees	20
Miscellaneous Vendors	Legal	3
Ginoli & Company	Accountants	2,660
U.S. Bank	Accountants	1,532
CDW	Computer Services	1,637
Polaris Group	Professional Fees	1,569
Total (agree to Schedule V, line 19, column 8)		34,603

Royal Oaks Care Center
0046243

Period Beginning **1/1/2011**
Period End **12/31/2011**

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Esquire Solutions	571.93	100%	572
Henry County Recorder	82.00	100%	82
Heyl Royster Voelker & Allen	69.00	100%	69
Heyl Royster Voelker & Allen	309.77	100%	310
Telleen, Horberg, Smith & Carmen	7,906.37	100%	7,906
Home Office Allocation			
Heyl, Royster, Voelker & Allen			12
Henry County Recorder			1
Miscellaneous Vendors			3
Total Legal Fees			8,955

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

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

(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. $ **13,828** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **109,500**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,657**

(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. $ **9,418**

c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**

d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees