

		FOR BHF USE					

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2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

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>0046243</u></p> <p>Facility Name: <u>Royal Oaks Care Center</u></p> <p>Address: <u>605 E Church Box 600</u> <u>Kewanee</u> <u>61443</u> <small>Number City Zip Code</small></p> <p>County: <u>Henry</u></p> <p>Telephone Number: <u>(309) 852-3389</u> Fax # <u>(309) 853-1838</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>03/01/2003</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 checked="" type="checkbox"/> "Sub-S" Corp. <input 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 checked="" type="checkbox"/> "Sub-S" Corp. <input 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>1/1/2013</u> to <u>12/31/2013</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;">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="width:15%; padding: 5px;">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 checked="" type="checkbox"/> "Sub-S" Corp. <input 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 Royal Oaks Care Center

0046243 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 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	44,232	3,488	1,875	49,595	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,232	3,488	1,875	49,595	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.94%

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 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 3/1/2003

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 200 and days of care provided 1,780

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	236,394	40,820		277,214		277,214	9,773	286,987		1
2	Food Purchase		335,240		335,240		335,240	(4,939)	330,301		2
3	Housekeeping	161,087	59,707		220,794		220,794	97	220,891		3
4	Laundry	92,265	23,471		115,736		115,736		115,736		4
5	Heat and Other Utilities			151,595	151,595		151,595	742	152,337		5
6	Maintenance	62,092	14,432	27,974	104,498		104,498	4,812	109,310		6
7	Other (specify):* Home Off. Ben. All.							553	553		7
8	TOTAL General Services	551,838	473,670	179,569	1,205,077		1,205,077	11,038	1,216,115		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	2,190,334	202,486	59,656	2,452,476		2,452,476	34	2,452,510		10
10a	Therapy			214,109	214,109		214,109		214,109		10a
11	Activities	90,182	329		90,511		90,511	(20,634)	69,877		11
12	Social Services	94,236			94,236		94,236		94,236		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	2,374,752	202,815	284,765	2,862,332		2,862,332	(20,600)	2,841,732		16
	C. General Administration										
17	Administrative			371,200	371,200		371,200	(304,700)	66,500		17
18	Directors Fees										18
19	Professional Services			2,381	2,381		2,381	39,750	42,131		19
20	Dues, Fees, Subscriptions & Promotions			11,393	11,393		11,393	760	12,153		20
21	Clerical & General Office Expenses	99,202	12,997	22,006	134,205		134,205	147,829	282,034		21
22	Employee Benefits & Payroll Taxes			383,904	383,904		383,904	1,187	385,091		22
23	Inservice Training & Education							195	195		23
24	Travel and Seminar							10	10		24
25	Other Admin. Staff Transportation			27,368	27,368		27,368	9,047	36,415		25
26	Insurance-Prop.Liab.Malpractice			75,063	75,063		75,063	1,747	76,810		26
27	Other (specify):* Home Off. Ben. All.							11,211	11,211		27
28	TOTAL General Administration	99,202	12,997	893,315	1,005,514		1,005,514	(92,964)	912,550		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,025,792	689,482	1,357,649	5,072,923		5,072,923	(102,526)	4,970,397		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 Royal Oaks Care Center

#0046243

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			82,242	82,242		82,242	53,955	136,197			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,434	150,434		150,434	176,044	326,478			32
33	Real Estate Taxes			73,438	73,438		73,438	786	74,224			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			56,743	56,743		56,743	1,447	58,190			35
36	Other (specify):*											36
37	TOTAL Ownership			362,857	362,857		362,857	232,232	595,089			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		107,489		107,489		107,489		107,489			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			398,723	398,723		398,723		398,723			42
43	Other (specify):* Non-allowable Costs	24,823	3,749	88,473	117,045		117,045	(117,045)				43
44	TOTAL Special Cost Centers	24,823	111,238	487,196	623,257		623,257	(117,045)	506,212			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,050,615	800,720	2,207,702	6,059,037		6,059,037	12,661	6,071,698			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: 1/1/2013

Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,148)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,551)	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	(258)	30		9
10	Interest and Other Investment Income	(56,253)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(301)	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	(55,564)	43		18
19	Entertainment				19
20	Contributions	(100)	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	(898)	43		24
25	Fund Raising, Advertising and Promotional	(32,578)	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	(49,856)	various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (202,507)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	215,168	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 215,168		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 12,661		37

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

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

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

Royal Oaks Care Center

ID# 0046243

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (14,435)	43	1
2	X-Rays-Part A	(4,674)	43	2
3	Offset Transportation Revenue	(20,634)	11	3
4	Offset Miscellaneous Office Supplies Revenue	(2,108)	21	4
5	Offset Chamber of Commerce Dues	(550)	20	5
6	Resident Flowers	(279)	43	6
7	Offset disallowed Air Travel expense	(6,686)	43	7
8	Offset Special Events	21	43	8
9	Disallowed Medicare Withholding Interest	(511)	32	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(49,856)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	9,773	0	0	0	0	0	0	0	0	0	9,773	1
2	Food Purchase	(5,148)	209	0	0	0	0	0	0	0	0	0	(4,939)	2
3	Housekeeping	0	97	0	0	0	0	0	0	0	0	0	97	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	742	0	0	0	0	0	0	0	0	0	742	5
6	Maintenance	0	4,787	0	25	0	0	0	0	0	0	0	4,812	6
7	Other (specify):*	0	553	0	0	0	0	0	0	0	0	0	553	7
8	TOTAL General Services	(5,148)	16,161	0	25	0	0	0	0	0	0	0	11,038	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	34	0	0	0	0	0	0	0	0	0	34	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(20,634)	0	0	0	0	0	0	0	0	0	0	(20,634)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(20,634)	34	0	0	0	0	0	0	0	0	0	(20,600)	16
	C. General Administration													
17	Administrative	0	(304,700)	0	0	0	0	0	0	0	0	0	(304,700)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	20,604	0	19,146	0	0	0	0	0	0	0	39,750	19
20	Fees, Subscriptions & Promotions	(550)	0	1,310	0	0	0	0	0	0	0	0	760	20
21	Clerical & General Office Expenses	(2,108)	0	121,115	28,822	0	0	0	0	0	0	0	147,829	21
22	Employee Benefits & Payroll Taxes	0	0	0	1,187	0	0	0	0	0	0	0	1,187	22
23	Inservice Training & Education	0	0	195	0	0	0	0	0	0	0	0	195	23
24	Travel and Seminar	0	0	10	0	0	0	0	0	0	0	0	10	24
25	Other Admin. Staff Transportation	0	0	9,047	0	0	0	0	0	0	0	0	9,047	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,747	0	0	0	0	0	0	0	0	1,747	26
27	Other (specify):*	0	0	11,211	0	0	0	0	0	0	0	0	11,211	27
28	TOTAL General Administration	(2,658)	(284,096)	144,635	49,155	0	0	0	0	0	0	0	(92,964)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(28,440)	(267,901)	144,635	49,180	0	0	0	0	0	0	0	(102,526)	29

STATE OF ILLINOIS

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2013 Ending:

Summary B

12/31/2013

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(258)	0	8,029	46,184	0	0	0	0	0	0	0	53,955	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(56,764)	0	13,356	219,452	0	0	0	0	0	0	0	176,044	32
33	Real Estate Taxes	0	0	786	0	0	0	0	0	0	0	0	786	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,447	0	0	0	0	0	0	0	0	1,447	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(57,022)	0	23,618	265,636	0	0	0	0	0	0	0	232,232	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(117,045)	0	0	0	0	0	0	0	0	0	0	(117,045)	43
44	TOTAL Special Cost Centers	(117,045)	0	0	0	0	0	0	0	0	0	0	(117,045)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(202,507)	(267,901)	168,253	314,816	0	0	0	0	0	0	0	12,661	45

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 9,773	\$ 9,773	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	209	209	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	97	97	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	742	742	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,787	4,787	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	553	553	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	34	34	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	371,200	Petersen Health Care, Inc.	100.00%	66,500	(304,700)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	20,604	20,604	12
13	V							13
14	Total		\$ 371,200			\$ 103,299	\$ * (267,901)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,310	\$	1,310	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	121,115		121,115	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	195		195	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	10		10	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	9,047		9,047	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,747		1,747	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,211		11,211	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	8,029		8,029	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	13,356		13,356	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	786		786	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%	1,447		1,447	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		\$			\$ 168,253	\$ *	168,253	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:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	25	25	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%	19,146	19,146	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	0		26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	28,822	28,822	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	1,187	1,187	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%	0		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%	46,184	46,184	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	219,452	219,452	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%	0		38	
39	Total		\$			\$ 314,816	\$ *	314,816	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:

1/1/2013

Ending:

12/31/2013

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 J	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 Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankf	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	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:

1/1/2013

Ending:

12/31/2013

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:

1/1/2013

Ending:

12/31/2013

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			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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, 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	1,560,986	75	\$ 307,592	\$ 295,212	49,595	\$ 9,773	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	49,595	209	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	49,595	97	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	49,595	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	49,595	742	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	49,595	4,787	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	49,595	553	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	49,595	34	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	49,595	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	49,595	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	49,595	66,500	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	49,595	20,604	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	49,595	1,310	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	49,595	121,115	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	49,595	195	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	49,595	10	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	49,595	9,047	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	49,595	1,747	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	49,595	11,211	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	49,595	8,029	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	49,595	13,356	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	49,595	786	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	49,595	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	49,595	1,447	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 271,552	25

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	161,888	7		49,595		1
2	2	Food	Resident Days	161,888	7		49,595		2
3	3	Housekeeping	Resident Days	161,888	7		49,595		3
4	4	Laundry	Resident Days	161,888	7		49,595		4
5	5	Utilities	Resident Days	161,888	7		49,595		5
6	6	Maintenance	Resident Days	161,888	7	80	49,595	25	6
7	7	Mgmt. Allocation of Benefits	Resident Days	161,888	7		49,595		7
8	10	Nursing and Medical Records	Resident Days	161,888	7		49,595		8
9	15	Mgmt. Allocation of Benefits	Resident Days	161,888	7		49,595		9
10	17	Administrative	Resident Days	161,888	7		49,595		10
11	19	Professional Services	Resident Days	161,888	7	62,499	49,595	19,146	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	161,888	7		49,595		12
13	21	Clerical and General Office	Resident Days	161,888	7	94,081	49,595	28,822	13
14	22	Employee Benefits & Payroll	Resident Days	161,888	7	3,874	49,595	1,187	14
15	23	Inservice Training & Education	Resident Days	161,888	7		49,595		15
16	24	Travel and Seminar	Resident Days	161,888	7		49,595		16
17	25	Other Admin. Staff Transport.	Resident Days	161,888	7		49,595		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	161,888	7		49,595		18
19	27	Mgmt. Allocation of Benefits	Resident Days	161,888	7		49,595		19
20	30	Depreciation	Resident Days	161,888	7	150,752	49,595	46,184	20
21	32	Interest	Resident Days	161,888	7	716,337	49,595	219,452	21
22	33	Real Estate Taxes	Resident Days	161,888	7		49,595		22
23	34	Rent-Facility and Grounds	Resident Days	161,888	7		49,595		23
24	35	Rent-Equipment & Vehicles	Resident Days	161,888	7		49,595		24
25	TOTALS					\$ 1,027,623	\$	\$ 314,816	25

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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		8	9	10	Reporting Period Interest Expense					
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO											Original	Balance		
A. Directly Facility Related																	
Long-Term																	
1	First Merit		X	Mortgage	Varies	2/1/12	\$ 3,337,200	\$ 3,167,269	01/31/17	Varies	\$ 136,425	1					
2	First Merit		X	Construction Loan	Varies	5/1/13	400,000	346,000	02/28/2017	Varies	13,498	2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 3,737,200	\$ 3,513,269			\$ 149,923	9					
B. Non-Facility Related*																	
10												10					
11											(56,253)	11					
12											13,356	12					
13											219,452	13					
14	TOTAL Non-Facility Related						\$	\$			\$ 176,555	14					
15	TOTALS (line 9+line14)						\$ 3,737,200	\$ 3,513,269			\$ 326,478	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* 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 2012 report.				\$	70,020 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.)	2012			\$	70,666 2
3. Under or (over) accrual (line 2 minus line 1).				\$	646 3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	72,792 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		786 6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	74,224 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2008	<u>67,577</u>	8		
	2009	<u>63,922</u>	9		
	2010	<u>67,972</u>	10		
	2011	<u>67,985</u>	11		
	2012	<u>70,666</u>	12		
Accrual based on prior year tax bill.					
				FOR BHF USE ONLY	
				13	FROM R. E. TAX STATEMENT FOR 2012 \$ 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.

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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 Royal Oaks Care Center

0046243 Report Period Beginning:

1/1/2013 Ending:

12/31/2013

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<u>Facility</u>	<u>362,419</u>	<u>2003</u>	<u>\$ 200,000</u>	1
2					2
3	TOTALS	362,419		\$ 200,000	3

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	200	2003	1998	\$ 1,490,095	\$	39	\$ 38,208	\$ 38,208	\$ 411,515	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Architectural Fees	2003	2010			15	134	134	1,281	9
10	Water Softener	2003	14,625			7			14,625	10
11	Disposer	2003	1,231			7			1,231	11
12	Hot Water Heater	2003	5,892			7			5,892	12
13	Parking lot	2004	25,762			15	1,717	1,717	18,030	13
14	Service Road	2004	6,940			15	463	463	4,282	14
15	Sidewalk	2004	2,600			15	173	173	1,586	15
16	Air Conditioning	2004	5,101			25	204	204	1,863	16
17	Fire Alarm	2004	5,810			25	232	232	2,119	17
18	Security System	2004	1,206			7			1,206	18
19	Water Heater	2005	6,518			30	217	217	1,808	19
20	New Flooring	2005	5,440			10	544	544	4,397	20
21	New Roof	2005	22,002			30	733	733	5,864	21
22	New Heating and Air conditioning	2006	6,378			15	425	425	3,400	22
23	Driveway	2007	7,625			15	508	508	3,312	23
24	Sidewalk	2007	7,200			15	480	480	3,120	24
25	Fire Alarm	2007	1,398			10	140	140	910	25
26	Smoke Detectors	2007	4,400			10	440	440	2,420	26
27	Water Heater	2007	11,619			10	1,162	1,162	7,553	27
28	Water Storage Tank	2008	5,647			5	562	562	5,647	28
29	Rooftop Heating Unit	2008	27,573			5	2,760	2,760	27,573	29
30	Roof	2008	72,265			39	1,852	1,852	10,186	30
31	Roof Repairs	2008	5,673			39	146	146	803	31
32	Water Heater	2009	3,240			5	648	648	2,916	32
33	Rooftop Cooling Unit	2009	13,500			5	2,700	2,700	12,150	33
34	Boiler	2010	9,033			15	602	602	2,107	34
35	Hot Water Heater	2010	2,998			7	428	428	1,498	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:

1/1/2013

Ending:

12/31/2013

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Roof Repairs	2010	\$ 13,359	\$	7	\$ 1,908	\$ 1,908	\$ 6,678	37
38	Water Heater	2010	6,120		10	612	612	2,142	38
39	Water Pipe Repair	2011	5,544		7	792	792	1,980	39
40	Water Heater	2012	3,637		7	520	520	780	40
41	Water Heater	2012	3,673		7	524	524	786	41
42	Sprinkler System	2012	159,900		25	6,396	6,396	9,594	42
43	Carpeting-Lobby and Main Area	2013	31,230		15	1,041	1,041	1,041	43
44	Roof Replacement	2013	155,855		25	3,117	3,117	3,117	44
45	Flooring-Dining Hall	2013	12,409		15	414	414	414	45
46	Cabinetry-Nurses Station	2013	16,496		15	550	550	550	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	Land Improvements Booked			2,834			(2,834)		63
64	Building Booked			38,229			(38,229)		64
65	Building Improvement Booked			28,936			(28,936)		65
66									66
67	2013-Home Office Allocation-Building Improvements		23,320			559	559		67
68	2013-Home Office Allocation-Land Improvements		2,177			139	139		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,207,501	\$ 69,998		\$ 72,050	\$ 2,052	\$ 586,376	70

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

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	\$ 90,150	\$ 956	\$ 9,733	\$ 8,777	5-10 yrs.	\$ 51,268	71
72	Current Year Purchases	17,985	11,288	899	(10,389)	10 yrs.	899	72
73	Fully Depreciated Assets	548,087					548,087	73
74	Home Office Allocation			53,515	53,515			74
75	TOTALS	\$ 656,222	\$ 12,244	\$ 64,147	\$ 51,903		\$ 600,254	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)	\$ 3,094,756	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 82,242	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 136,197	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 53,955	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,217,663	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	N/A				87
88					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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 48,603 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2012 Ford E250	\$ 822.05	\$ 9,587	17
18					18
19					19
20					20
21	TOTAL		\$ 822.05	\$ 9,587	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 1/1/2013

Period End 12/31/2013

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 36,488
Dishwasher	2,006
Laundry Equipment	-
Copier	8,662
Home Office Allocation	1,447
	<u>48,603</u>

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2013 Ending: 12/31/2013
 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. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,939	\$ 74,093	\$	4,939	\$ 74,093	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		885	13,283		885	13,283	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		8,442	126,623		8,442	126,623	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				107,489		107,489	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify): <u>Respiratory Therapy</u>	10A(3)			7	110		7	110	13	
14	TOTAL			\$	14,273	\$ 214,109	\$ 107,489	14,273	\$ 321,598	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: 1/1/2013

Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 7,247,652	\$ 7,247,652	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>264,587</u>)	896,596	896,596	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,221	70,221	6
7	Other Prepaid Expenses	38,824	38,824	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Deposits, PPD Lease, Advances</u>	112,838	112,838	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,366,131	\$ 8,366,131	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	1,513,415	14
15	Leasehold Improvements, at Historical Cost	612,450	694,086	15
16	Equipment, at Historical Cost	710,209	687,255	16
17	Accumulated Depreciation (book methods)	(1,228,381)	(1,217,663)	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)	\$ 1,834,501	\$ 1,877,093	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 10,200,632	\$ 10,243,224	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 719,097	\$ 719,097	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	178,637	178,637	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,999	11,999	31
32	Accrued Real Estate Taxes(Sch.IX-B)	72,792	72,792	32
33	Accrued Interest Payable	13,147	13,147	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	91,274	91,274	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,086,946	\$ 1,086,946	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,513,269	3,513,269	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>A/P-C.N.A. Insurance</u>	102,971	102,971	43
44	<u>Due to/Due From</u>	1,042,993	1,042,993	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,659,233	\$ 4,659,233	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,746,179	\$ 5,746,179	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,454,453	\$ 4,497,045	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 10,200,632	\$ 10,243,224	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,571,920	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,571,918	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(117,465)	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)	\$ (117,465)	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)	\$ 4,454,453	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,604,443	1
2	Discounts and Allowances for all Levels	(333,970)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,270,473	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	386,892	6
7	Oxygen	314	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 387,206	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	5,148	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	176,633	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	16,160	20
21	Other Medical Services	6,957	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 204,898	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	56,253	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 56,253	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	2,108	28
28a	Transportation Revenue	20,634	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 22,742	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,941,572	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,205,077	31
32	Health Care	2,862,332	32
33	General Administration	1,005,514	33
B. Capital Expense			
34	Ownership	362,857	34
C. Ancillary Expense			
35	Special Cost Centers	224,534	35
36	Provider Participation Fee	398,723	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,059,037	40
41	Income before Income Taxes (line 30 minus line 40)**	(117,465)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (117,465)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 4,551,829	44
45	Private Pay - Net Inpatient Revenue	456,714	45
46	Medicare - Net Inpatient Revenue	283,465	46
47	Other-(specify) <u>Veterans -Net Patient Revenue</u>		47
48	Other-(specify) <u>Charity and Insurance Contractual Allowance</u>	(21,535)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,270,473	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Royal Oaks Care Center

0046243

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,318	2,366	\$ 78,106	\$ 33.01	1
2	Assistant Director of Nursing	1,387	1,387	27,041	19.50	2
3	Registered Nurses	8,648	8,872	204,221	23.02	3
4	Licensed Practical Nurses	37,918	39,449	711,812	18.04	4
5	CNAs & Orderlies	100,684	104,831	1,036,968	9.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	348	348	3,400	9.77	9
10	Activity Assistants	4,214	4,308	40,123	9.31	10
11	Social Service Workers	7,355	7,561	94,236	12.46	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,580	13.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,347	23,929	207,814	8.68	15
16	Dishwashers					16
17	Maintenance Workers	3,924	4,069	62,092	15.26	17
18	Housekeepers	17,347	18,436	161,087	8.74	18
19	Laundry	9,048	9,531	92,265	9.68	19
20	Administrator	2,080	2,080	66,500	31.97	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	6,556	6,852	99,202	14.48	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	653	653	10,099	15.47	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	11,925	12,140	193,569	15.94	33
34	TOTAL (lines 1 - 33)	239,832	248,892	\$ 3,117,115 *	\$ 12.52	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 11,000	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 9,681	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)	\$ 20,681		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	837 \$ 21,693	L10, C3	50
51	Licensed Practical Nurses	1,030 28,852	L10, C3	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	1,867 \$ 50,545		53

Royal Oaks Care Center
0046243
Period Beginning
Period End

1/1/2013
12/31/2013

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	4,334	4,485	110,300	24.59
Psychological Director	693	693	11,787	17.01
Transportation	4,818	4,882	46,659	9.56
Marketing	2,080	2,080	24,823	11.93
TOTAL	<u>11,925</u>	<u>12,140</u>	<u>193,569</u>	

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			Ownership %	Amount	D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function				Description	Amount	Description	Amount		
Angela Ince	Administrator	0	66,500	Workers' Compensation Insurance	\$ 86,609	IDPH License Fee	\$ 3,980			
				Unemployment Compensation Insurance	84,703	Advertising: Employee Recruitment	163			
				FICA Taxes	227,718	Health Care Worker Background Check				
				Employee Health Insurance	(24,523)	(Indicate # of checks performed)				
				Employee Meals		Patient Background Checks	63	6,340		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	360			
				Employee Relations	8,296	Miscellaneous Dues & Subscriptions	550			
				Employee Retirement	1,101	Home Office Allocation	1,310			
				Home Office Allocation	1,187					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,500	TOTAL (agree to Schedule V, line 22, col.8)			\$ 385,091	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,153
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount	Description	Amount		
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 371,200				Out-of-State Travel	\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 371,200	N/A			In-State Travel			
C. Professional Services										
Vendor/Payee	Type		Amount							
Honkamp, Kruger and Co.	Accounting Fees		\$ 1,152							
Comcast	Computer Services		1,229							
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,381	TOTAL			\$	Seminar Expense		
							Home Office Allocation		10	
							Entertainment Expense		()	
							TOTAL (agree to Sch. V, line 24, col. 8)		\$ 10	

* Attach copy of IMRF notifications

**See instructions.

Royal Oaks Care Center

0046243

Period Beginning

1/1/2013

Period End

12/31/2013

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,381
Home Office Allocation		
SmithAmundsen	Legal	1225
Cole, Schotz, Meisel	Legal	674
Black, Hedin, Ballard	Legal	61
Medicare	Legal	670
Estate of Dorothy Frolker	Legal	706
Ginoli & Company	Accountants	14772
IC System	Computer Services	2103
Miscellaneous	Computer Services	190
Odessian LLC	Computer Services	96
CCH	Computer Services	28
Lexis-Nexis	Computer Services	11
Ipanema Solutions	Computer Services	26
Macquarie Technology Services	Computer Services	174
Advanced Answers on Demand	Computer Services	9069
TeamViewer	Computer Services	29
Stratus Networks	Computer Services	731
Kemper Technology	Computer Services	565
AT&T	Computer Services	10
Medifax	Computer Services	82
Vision Share/Ability Network	Computer Services	1242
Barracuda	Computer Services	224
CIAN	Computer Services	298
Comcast	Computer Services	66
Emdeon	Computer Services	100
Marotta Gund Budd & Dzera	Other Prof Fees	2776

David Budde	Other Prof Fees	58
Pharmacy Price Mangement	Other Prof Fees	229
All Scripts	Other Prof Fees	408
Pinnacle Actuarial Resources	Other Prof Fees	3052
Healthlink	Other Prof Fees	75
Total (agree to Schedule V, line 19, column 8)		<u><u>42,131</u></u>

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

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

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

1/1/2013

Ending:

12/31/2013**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. \$ 22,121 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. \$ 398,723
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 5,148
- (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. \$ 20,634
- 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Royal Oaks Care Center

10:05 AM

5/21/2014

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	12,661	equal to	12,661	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	326,478	equal to	326,478	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	74,224	equal to	74,224	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	136,197	equal to	136,197	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	58,190	equal to	58,190	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	214,109	equal to	214,109	0	O.K.	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	107,489	equal to	107,489	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,205,077	equal to	1,205,077	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,862,332	equal to	2,862,332	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administation	1,005,514	equal to	1,005,514	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	362,857	equal to	362,857	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	224,534	equal to	224,534	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+t	N/A	38to41+43	4
Income Stat. Prov. Partic.	398,723	equal to	398,723	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,190,334	equal to	2,190,334	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	90,182	equal to	90,182	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	94,236	equal to	94,236	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	236,394	equal to	236,394	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	62,092	equal to	62,092	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	161,087	equal to	161,087	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	92,265	equal to	92,265	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	66,500	equal to		#VALUE!	#VALUE!	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	99,202	equal to	99,202	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,117,115	equal to	3,050,615	66,500	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	11,000	< or = to	11,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	60,226	< or = to	59,656	570	FAILED	Pg20 X14..X16+	B. & C.	i7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	66,500	equal to		#VALUE!	#VALUE!	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	371,200	equal to	371,200	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3

Supp. Sched.- Prof. Serv.	2,381	equal to	2,381	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	385,091	equal to	385,091	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	12,153	equal to	12,153	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	10	equal to	10	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	398,723	equal to	398,723	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	1,187	-1,187	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,780	equal to	1,875	-95	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	215,168	equal to	215,168	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4l	B.	14	8
Total loan balance	3,513,269	equal to	3,513,269	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	72,792	equal to	72,792	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	200,000	equal to	200,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,207,501	equal to	2,207,501	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	687,255	equal to	687,255	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,217,663	equal to	1,217,663	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	4,454,453	equal to	4,454,453	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-117,465	equal to	-117,465	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31...f	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	10,200,632	equal to	10,200,632	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	236,394	40,820	0	277,214	0	277,214	9,773	286,987
2. Food Purchase	0	335,240	0	335,240	0	335,240	-4,939	330,301
3. Housekeeping	161,087	59,707	0	220,794	0	220,794	97	220,891
4. Laundry	92,265	23,471	0	115,736	0	115,736	0	115,736
5. Heat and Other Utilities	0	0	151,595	151,595	0	151,595	742	152,337
6. Maintenance	62,092	14,432	27,974	104,498	0	104,498	4,812	109,310
7. Other (specify)*	0	0	0	0	0	0	553	553
8. Total General Services	551,838	473,670	179,569	1,205,077	0	1,205,077	11,038	1,216,115
9. Medical Director	0	0	11,000	11,000	0	11,000	0	11,000
10. Nursing & Medical Records	2,190,334	202,486	59,656	2,452,476	0	2,452,476	34	2,452,510
10a. Therapy	0	0	214,109	214,109	0	214,109	0	214,109
11. Activities	90,182	329	0	90,511	0	90,511	-20,634	69,877
12. Social Services	94,236	0	0	94,236	0	94,236	0	94,236
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,374,752	202,815	284,765	2,862,332	0	2,862,332	-20,600	2,841,732
17. Administrative	0	0	371,200	371,200	0	371,200	-304,700	66,500
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	2,381	2,381	0	2,381	39,750	42,131
20. Fees, Subscriptions & Promotion	0	0	11,393	11,393	0	11,393	760	12,153
21. Clerical & General Office	99,202	12,997	22,006	134,205	0	134,205	147,829	282,034
22. Employee Benefits & Payroll	0	0	383,904	383,904	0	383,904	1,187	385,091
23. Inservice Training & Education	0	0	0	0	0	0	195	195
24. Travel and Seminar	0	0	0	0	0	0	10	10
25. Other Admin. Staff Trans	0	0	27,368	27,368	0	27,368	9,047	36,415
26. Insurance-Prop.Liab.Malpractice	0	0	75,063	75,063	0	75,063	1,747	76,810
27. Other (specify)*	0	0	0	0	0	0	11,211	11,211
28. Total General Adminis	99,202	12,997	893,315	1,005,514	0	1,005,514	-92,964	912,550
29. Total General Administrative	3,025,792	689,482	1,357,649	5,072,923	0	5,072,923	-102,526	4,970,397
30. Depreciation	0	0	82,242	82,242	0	82,242	53,955	136,197
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	150,434	150,434	0	150,434	176,044	326,478
33. Real Estate	0	0	73,438	73,438	0	73,438	786	74,224

34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	56,743	56,743	0	56,743	1,447	58,190
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	362,857	362,857	0	362,857	232,232	595,089
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	107,489	0	107,489	0	107,489	0	107,489
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	398,723	398,723	0	398,723	0	398,723
43. Other (specify):*	24,823	3,749	88,473	117,045	0	117,045	-117,045	0
44. Total Special Cost Ce	24,823	111,238	487,196	623,257	0	623,257	-117,045	506,212
45. Grand Total	3,050,615	800,720	2,207,702	6,059,037	0	6,059,037	12,661	6,071,698

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	7,247,652	7,247,652
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	896,596	896,596
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	70,221	70,221
7. Other Prepaid Expenses	25,167	25,167
8. Accounts Receivable-Owner/Related Party	-1,042,993	-1,042,993
9. Other (specify):	112,838	112,838
10. Total current assets	7,309,481	7,309,481
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	250,128	200,000
14. Buildings, at Historical Cost	1,490,095	1,513,415
15. Leasehold Improvements, Historical Cost	612,450	694,086
16. Equipment, at Historical Cost	710,209	687,255
17. Accumulated Depreciation (book methods)	-1,228,381	-1,217,663
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,834,501	1,877,093
25. Total Assets	9,143,982	9,186,574
CURRENT LIABILITIES		
26. Accounts Payable	719,097	719,097
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	178,637	178,637
31. Accrued Taxes Payable	11,999	11,999
32. Accrued Real Estate Taxes	72,792	72,792
33. Accrued Interest Payable	13,147	13,147
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	91,274	91,274

37. Other Current Liabilities (specify):	-13,657	-13,657
38. Total Current Liabilities	1,073,289	1,073,289
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	3,513,269	3,513,269
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	102,971	102,971
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	3,616,240	3,616,240
46. Total Liabilities	4,689,529	4,689,529
47. Total Equity	4,454,453	4,497,045
48. Total Liabilities and Equity	9,143,982	

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,604,443
2. Discounts and Allowances for all Levels	-333,970
Subtotal - Inpatient Care	5,270,473
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	386,892
7. Oxygen	314
Subtotal - Anciliary Revenue	387,206
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	5,148
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	176,633
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	16,160
21. Other Medical Services	6,957
22. Laundry	0
Subtotal - Other Operating Revenue	204,898
24. Contributions	0
25. Interest and Other Investments Income	56,253
Subtotal - Non-Operating Revenue	56,253
27. Other Revenue (specify):	0
28. Other Revenue (specify):	22,742
Subtotal - Other Revenue	22,742
30. Total Revenue	5,941,572
31. General Services	1,155,468
32. Health Care	2,665,735
33. General Administration	984,235
34. Ownership	311,065

35. Special Cost Centers	233,367
35. Provider Participation Fee	602,921
37. Other	0
40. Total Expenses	5,952,791
41. Income Before Income Taxes	-11,219
42. Income Taxes	0
43. Net Income or Loss for the Year	-11,219

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!

5/21/2014 10:05:51 AM

HSA Number: _____ 10 Name: Royal Oaks Care Center

Cost report period From: 1/1/2013 To: 12/31/2013 Base Number: 456

If this is an ICF/DD 16 facility, enter a 1 in cell C6

Licensed bed days: 73,000 Occupancy: N 49,595 Pct. of occupancy: 67.94%

Illinois Public Aid Support Rate: \$ _____

Genl Services Salary/Wage: 551,838 Col 1, Line 8 ---Audit Adj: _____

Genl Admin Salary/Wage: 99,202 Col 1, Line 28 ---Audit Adj: _____

Total Salary Wage: 3,050,615 Col 1, Line 44 ---Audit Adj: _____

Employee Benefits: 385,091 Col 8, Line 22 ---Audit Adj: _____

Total General Services: 1,216,115 Col 8, Line 8 ---Audit Adj: _____

Total General Admin: 912,550 Col 8, Line 28 ---Audit Adj: _____

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

- 1 Determine the proportion of general services wages to total wages.
- 2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.
- 3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)
Divided by Total Wages (Column 1, Line 44)
General service wages as percent of total wages
Employee Benefits (Column 10, Line 22)

Allocation of Employee Benefits to General Services Costs
Plus Total General Services (Column 10, Line 8)
New Total General Services Cost

B.

General Administration

- 1 Determine the proportion of General Administration wages to total wages.
- 2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.
- 3 Add the proportioned fringe amount to your total General Administration expenses.
- 4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).
Divided by Total Wages (Column 1, Line 45)
General administration wages as a percent of total wages

Employee Benefits (Column 10, Line 22)
Allocation of Employee Benefits to General Admin. Costs
Plus Total General Administration (Column 10, Line 28)
Minus Total Fringe (Column 10, Line 22)
New Total General Administration Cost

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation factors are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month = 13 divided by 2 =
Beginning Day + Ending Day = 32 divided by 60.8 =
Beginning Year + Ending Year = 226 multiplied by 6 =

Sum of the three lines
Subtract from the sum

Base Number (expressed as a whole number, fraction dropped)

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:
General Administration Multiplier:

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)
General Services Multiplier (Step II-B)

Updated General Services Cost

2 Multiply New Total General Administration Cost
(from Step I-B) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)
General Administration Multiplier (Step II-B)

Updated General Services Cost

3 Total Updated Support Costs (1 + 2)

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)
Total Patient Days (Cost Report)

Support Costs per Diem

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days
Multiplied by

Minus total Patient Days

One-third of difference

Plus Total Patient Days

Adjusted Occupancy

Total Support Costs (Step II, C, 3, above)
Divided by Adjusted Occupancy

Support Costs Per Diem

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

- A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.
- B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Plus Support Costs Per Diem

Support Rate if costs are between 35th and 75th percentile

- C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus \$.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA
Minus Support Costs Per Diem

Difference

Multiply the Difference by

One-Half of the Difference

Compare one-half the difference to the
profit ceiling for your HSA in Table II and

Enter the Lower of the Two Amounts

Plus Support Costs Per Diem

Support Rate if support costs less than 35th percentile

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above

75th Percentile is

35th Percentile is

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

\$551,838
\$3,050,615
 18.0894%
\$385,091

 \$69,661
\$1,216,115
\$1,285,776

\$99,202
\$3,050,615
 3.2519%

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF)
SupportRate per

HSA
1
2
3
4
5
6
7
8
9
10
11

\$385,091
\$12,523
\$912,550
\$385,091
\$539,982

6.5
0.526315789
1356

1363.026316
907.00

456

1
1

\$1,285,776
1

\$1,285,776

\$539,982
1
\$539,982
\$1,825,758

\$32.78

\$1,825,758
49,595
\$36.81

73,000
0.93
67,890

49,595
18,295

6,098

49,595

55,693

\$1,825,758
55693

\$32.78

\$48.45
\$32.78
\$15.67

0.5
\$7.84

\$32.78

40.62

\$48.45
\$32.78
\$15.67

0.5

\$7.84

4.345

\$4.345

\$32.78

\$37.13

\$37.13

\$48.45

\$39.86

7/DD 16 Facilities)

Percentiles by HSA

Not updated with current figures

<u>75th Percentile</u>	<u>35th Percentile</u>	<u>Below 35th Profit Ceiling</u>
34.86	27.19	3.885
33.30	25.97	3.715
32.74	25.54	3.650
33.30	25.97	3.715
30.46	23.75	3.405
40.44	31.54	4.500
40.44	31.54	4.500
40.44	31.54	4.500
37.60	29.32	4.190
34.86	27.19	3.885
32.73	25.52	3.655