

Facility Name & ID Number Royal Oaks Care Center

0046243 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	41,998	7,456	2,349	51,803	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,998	7,456	2,349	51,803	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.96%

D. How many bed-hold days during this year were paid by the Department?

0 (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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 03/01/2003

J. Was the facility purchased or leased after January 1, 1978?

YES Date 03/01/2003 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 2,349

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 01/01/06 Ending: 12/31/06

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	199,538	33,377		232,915		232,915	3,684	236,599		1
2	Food Purchase		259,961		259,961		259,961	(6,309)	253,652		2
3	Housekeeping	121,365	21,936		143,301		143,301	163	143,464		3
4	Laundry	82,177	26,567		108,744		108,744		108,744		4
5	Heat and Other Utilities			191,756	191,756		191,756	683	192,439		5
6	Maintenance	49,818	30,142	7,012	86,972		86,972	9,368	96,340		6
7	Other (specify):* Home Office Benefits							1,476	1,476		7
8	TOTAL General Services	452,898	371,983	198,768	1,023,649		1,023,649	9,065	1,032,714		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,469,811	154,921	747	1,625,479		1,625,479	13,318	1,638,797		10
10a	Therapy	77,868		191	78,059		78,059	1,223	79,282		10a
11	Activities	83,380	3,701	5,317	92,398		92,398		92,398		11
12	Social Services	74,602	244		74,846		74,846		74,846		12
13	CNA Training										13
14	Program Transportation	43,130			43,130		43,130	(326)	42,804		14
15	Other (specify):* Home Office Benefits							4,117	4,117		15
16	TOTAL Health Care and Programs	1,748,791	158,866	18,255	1,925,912		1,925,912	18,332	1,944,244		16
	C. General Administration										
17	Administrative	95,583		170,000	265,583		265,583	(133,694)	131,889		17
18	Directors Fees										18
19	Professional Services			14,020	14,020		14,020	14,750	28,770		19
20	Dues, Fees, Subscriptions & Promotions			3,957	3,957		3,957	881	4,838		20
21	Clerical & General Office Expenses	32,973	8,617	7,250	48,840		48,840	58,527	107,367		21
22	Employee Benefits & Payroll Taxes			412,920	412,920		412,920	4,281	417,201		22
23	Inservice Training & Education			820	820		820	473	1,293		23
24	Travel and Seminar							806	806		24
25	Other Admin. Staff Transportation			18,380	18,380		18,380	3,770	22,150		25
26	Insurance-Prop.Liab.Malpractice			55,625	55,625		55,625	2,789	58,414		26
27	Other (specify):* Home Office Benefits							10,343	10,343		27
28	TOTAL General Administration	128,556	8,617	682,972	820,145		820,145	(37,074)	783,071		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,330,245	539,466	899,995	3,769,706		3,769,706	(9,677)	3,760,029		29

SEE ACCOUNTANTS' COMPILATION REPORT

*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.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number

Royal Oaks Care Center

#0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			134,831	134,831		134,831	13,000	147,831			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			163,189	163,189		163,189	49,960	213,149			32
33	Real Estate Taxes			65,568	65,568		65,568	1,692	67,260			33
34	Rent-Facility & Grounds							1,640	1,640			34
35	Rent-Equipment & Vehicles			16,973	16,973		16,973	859	17,832			35
36	Other (specify):*											36
37	TOTAL Ownership			380,561	380,561		380,561	67,151	447,712			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,060		45,060		45,060		45,060			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* Nonallowable Cost			165,458	165,458		165,458	(165,458)				43
44	TOTAL Special Cost Centers		45,060	274,958	320,018		320,018	(165,458)	154,560			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,330,245	584,526	1,555,514	4,470,285		4,470,285	(107,984)	4,362,301			45

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

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,209)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,165)	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	(1,430)	30		9
10	Interest and Other Investment Income	(7,798)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,949)	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				18
19	Entertainment				19
20	Contributions	(12,143)	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	(118,410)	43		24
25	Fund Raising, Advertising and Promotional	(2,034)	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 <u>See Page 5A</u>	(45,275)	Vari.		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (192,413)		\$	30

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)	84,429	Vari.	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 84,429		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (107,984)		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	Exceptional Care Program		x		44
45	Other-Attach Schedule		x		45
46	Other-Attach Schedule		x		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY					
48	49	50	51	52	

SEE ACCOUNTANTS' COMPILATION REPORT

Royal Oaks Care Center

ID# 0046243

Report Period Beginning: 01/01/06

Ending: 12/31/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Nonallowable marketing events	\$ (2,850)	43	1
2	Labs - Part A	(24,322)	43	2
3	X-Rays - Part A	(2,585)	43	3
4	Nonallowable Dues	(677)	20	4
5				5
6				6
7	Non-Allowable HO - Arcitect Fees	(1,150)	19	7
8	Non-Allowable HO - Travel Exp	(13,365)	24	8
9	Transportation Rev	(326)	14	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	(45,275)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	3,684	0	0	0	0	0	0	0	0	0	3,684	1
2	Food Purchase	(2,209)	181	0	0	0	0	0	0	0	0	0	(2,028)	2
3	Housekeeping	0	163	0	0	0	0	0	0	0	0	0	163	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	683	0	0	0	0	0	0	0	0	0	683	5
6	Maintenance	0	9,368	0	0	0	0	0	0	0	0	0	9,368	6
7	Other (specify):*	0	1,476	0	0	0	0	0	0	0	0	0	1,476	7
8	TOTAL General Services	(2,209)	15,555	0	0	0	0	0	0	0	0	0	13,346	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	13,318	0	0	0	0	0	0	0	0	0	13,318	10
10a	Therapy	0	1,223	0	0	0	0	0	0	0	0	0	1,223	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	(326)	0	0	0	0	0	0	0	0	0	0	(326)	14
15	Other (specify):*	0	4,117	0	0	0	0	0	0	0	0	0	4,117	15
16	TOTAL Health Care and Programs	(326)	18,658	0	0	0	0	0	0	0	0	0	18,332	16
	C. General Administration													
17	Administrative	0	(133,694)	0	0	0	0	0	0	0	0	0	(133,694)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,150)	15,900	0	0	0	0	0	0	0	0	0	14,750	19
20	Fees, Subscriptions & Promotions	(677)	1,558	0	0	0	0	0	0	0	0	0	881	20
21	Clerical & General Office Expenses	0	0	58,527	0	0	0	0	0	0	0	0	58,527	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	473	0	0	0	0	0	0	0	0	473	23
24	Travel and Seminar	(13,365)	0	14,171	0	0	0	0	0	0	0	0	806	24
25	Other Admin. Staff Transportation	0	0	3,770	0	0	0	0	0	0	0	0	3,770	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,789	0	0	0	0	0	0	0	0	2,789	26
27	Other (specify):*	0	0	10,343	0	0	0	0	0	0	0	0	10,343	27
28	TOTAL General Administration	(15,192)	(116,236)	90,073	0	(41,355)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(17,727)	(82,023)	90,073	0	(9,677)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	(1,430)	0	14,430	0	0	0	0	0	0	0	0	13,000	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(7,798)	0	57,758	0	0	0	0	0	0	0	0	49,960	32
33	Real Estate Taxes	0	0	1,692	0	0	0	0	0	0	0	0	1,692	33
34	Rent-Facility & Grounds	0	0	1,640	0	0	0	0	0	0	0	0	1,640	34
35	Rent-Equipment & Vehicles	0	0	859	0	0	0	0	0	0	0	0	859	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(9,228)	0	76,379	0	67,151	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):*	(165,458)	0	0	0	0	0	0	0	0	0	0	(165,458)	43
44	TOTAL Special Cost Centers	(165,458)	0	0	0	0	0	0	0	0	0	0	(165,458)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(192,413)	(82,023)	166,452	0	(107,984)	45							

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6A		See Attached Schedule 6A		

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,684	\$ 3,684	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	181	181	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	163	163	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	683	683	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	9,368	9,368	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,476	1,476	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	13,318	13,318	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	1,223	1,223	9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,117	4,117	10
11	V	17 Administrative	170,000	Petersen Health Care, Inc.	100.00%	36,306	(133,694)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	15,900	15,900	12
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	1,558	1,558	13
14	Total		\$ 170,000			\$ 87,977	\$ * (82,023)	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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 58,527	\$	58,527	15
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	473		473	16
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	14,171		14,171	17
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	3,770		3,770	18
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	2,789		2,789	19
20	V	27 Mgmt Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,343		10,343	20
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	14,430		14,430	21
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	8,015		8,015	22
23	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,692		1,692	23
24	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	1,640		1,640	24
25	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	859		859	25
26	V	32 Interest		Petersen Health Care, Inc.	100.00%	49,743		49,743	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		\$			\$ 166,452	\$ *	166,452	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: 01/01/06 Ending: 12/31/06

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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	2.27	4.54	Salary	\$ 36,306	L17,C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 36,306		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/06

Ending: 12/31/06

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 West 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	Patient Days	56	\$ 81,179	\$ 80,967	51,803	\$ 3,684	1
2	2	Food	Patient Days	56	3,989	0	51,803	181	2
3	3	Housekeeping	Patient Days	56	3,589	0	51,803	163	3
4	4	Laundry	Patient Days	56	0	0	51,803	0	4
5	5	Utilities	Patient Days	56	15,054	0	51,803	683	5
6	6	Maintenance	Patient Days	56	206,416	110,513	51,803	9,368	6
7	7	Mgmt. Allocation of Benefits	Patient Days	56	32,526	0	51,803	1,476	7
8	10	Nursing and Medical Records	Patient Days	56	293,462	289,197	51,803	13,318	8
9	10A	Therapy	Patient Days	56	26,945	0	51,803	1,223	9
10	15	Mgmt. Allocation of Benefits	Patient Days	56	90,724	0	51,803	4,117	10
11	17	Administrative	Patient Days	56	800,000	800,000	51,803	36,306	11
12	19	Professional Services	Patient Days	56	350,361	0	51,803	15,900	12
13	20	Due, Fees, Subs & Promos	Patient Days	56	34,325	0	51,803	1,558	13
14	21	Clerical & General Office	Patient Days	56	1,289,623	954,322	51,803	58,527	14
15	23	Inservice Training & Education	Patient Days	56	10,426	0	51,803	473	15
16	24	Travel and Seminar	Patient Days	56	312,259	0	51,803	14,171	16
17	25	Other Admin. Staff Transport	Patient Days	56	83,062	0	51,803	3,770	17
18	26	Insurance-Prop.Liab.Malpractice	Patient Days	56	61,457	0	51,803	2,789	18
19	27	Mgmt Allocation of Benefits	Patient Days	56	227,912	0	51,803	10,343	19
20	30	Depreciation	Patient Days	56	317,964	0	51,803	14,430	20
21	32	Interest	Patient Days	56	176,614	0	51,803	8,015	21
22	33	Real Estate Taxes	Patient Days	56	37,282	0	51,803	1,692	22
23	34	Rent - Facility & Grounds	Patient Days	56	36,133	0	51,803	1,640	23
24	35	Rent - Equipment & Vehicles	Patient Days	56	18,933	0	51,803	859	24
25	TOTALS				\$ 4,510,235	\$ 2,234,999		\$ 204,686	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>Interest</u>	<u>Patient Days</u>	<u>316,605</u>	<u>56</u>	<u>304,014</u>		<u>51,803</u>	<u>\$ 49,743</u>	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 304,014	\$		\$ 49,743	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	U S Bank		X	Mortgage	Varies	08/31/02	\$ 2,420,000	\$ 2,306,008	12/31/11	Varies	\$ 162,931	1					
2	Ford Credit		X	Van Purchase	\$541.00	04/17/03	30,965	8,021	07/13/08	0.0190	258	2					
3												3					
4							Allocation from Home Office				57,758	4					
5							Offset Interest Income				(7,798)	5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$541.00		\$ 2,450,965	\$ 2,314,029			\$ 213,149	9					
B. Non-Facility Related*																	
10												10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$	14					
15	TOTALS (line 9+line14)						\$ 2,450,965	\$ 2,314,029			\$ 213,149	15					

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

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 2005 report.		\$	56,178	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.)	2005	\$	61,246	2
3. Under or (over) accrual (line 2 minus line 1).		\$	5,068	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	60,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			1,692	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	67,260	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2001		8
	2002	56,100	9
	2003	58,874	10
	2004	62,532	11
	2005	61,246	12

Tax accrual is calculated using prior year tax bills.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Royal Oaks Care Center COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0046243

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (618) 283-4262 FAX #: (618) 283-4313

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>25-03-401-008</u>	<u>Nursing Home</u>	\$ <u>60,236.00</u>	\$ <u>60,236.00</u>
2. <u>25-03-401-009</u>	<u>Nursing Home</u>	\$ <u>1,009.60</u>	\$ <u>1,009.60</u>
3. _____	<u>Home Office Allocation</u>	\$ _____	\$ <u>1,692.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>61,245.60</u>	\$ <u>62,937.60</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

01/01/06

Ending:

12/31/06

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).

None

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: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: N/A

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 144,059	4
5										5
6	Allocation									6
7	From Home									7
8	Office		2006	30,896			1,352	1,352	1,352	8
Improvement Type**										
9	Architectural Fees		2003	2,010		15	134	134	343	9
10	Water Softener		2003	14,625		7	2,089	2,089	5,502	10
11	Disposer		2003	1,231		7	176	176	453	11
12	Hot Water Heater		2003	5,892		7	842	842	2,021	12
13	Parking lot		2004	25,762		15	1,717	1,717	6,011	13
14	Service Road		2004	6,940		15	463	463	1,041	14
15	Sidewalk		2004	2,600		15	173	173	375	15
16	Air Conditioning		2004	5,101		25	204	204	435	16
17	Fire Alarm		2004	5,810		25	232	232	495	17
18	Security System		2004	1,206		7	172	172	353	18
19	Water Heater		2005	6,518		30	217	217	289	19
20	New Flooring		2005	5,440		10	544	544	589	20
21	New Roof		2005	22,002		30	733	733	733	21
22	New Heating and Air conditioning		2006	6,378		15	425	425	425	22
23										23
24										24
25										25
26	Land Improvement Booked				2,354			(2,354)		26
27	Building Booked				38,229			(38,229)		27
28	Building Improvement Booked				2,069			(2,069)		28
29										29
30										30
31										31
32										32
33										33
34										34
35	2006 Allocation from home office - Leasehold improvements		2006	1,786			166	166	166	35
36	2006 Allocation from home office - Building Improvements		2006	50			3	3	3	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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$	37	
38								38	
39								39	
40								40	
41								41	
42								42	
43								43	
44								44	
45								45	
46								46	
47								47	
48								48	
49								49	
50								50	
51								51	
52								52	
53								53	
54								54	
55								55	
56								56	
57								57	
58								58	
59								59	
60								60	
61								61	
62								62	
63								63	
64								64	
65								65	
66								66	
67								67	
68								68	
69								69	
70	TOTAL (lines 4 thru 69)	\$	\$		\$	\$	\$	70	
			1,634,342		42,651		47,852	5,201	164,647

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 548,087	\$ 85,973	\$ 78,298	\$ (7,675)	7	\$ 225,856	71
72	Current Year Purchases	28,689		2,566	2,566	8	2,566	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			12,908	12,908			74
75	TOTALS	\$ 576,776	\$ 85,973	\$ 93,772	\$ 7,799		\$ 228,422	75

D. Vehicle Depreciation (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	\$ 6,207	\$ 6,207	\$	5	\$ 20,689	76
77										77
78										78
79										79
80	TOTALS			\$ 31,033	\$ 6,207	\$ 6,207	\$		\$ 20,689	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,442,151	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 134,831	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 147,831	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 13,000	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 413,758	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.

SEE ACCOUNTANTS' COMPILATION REPORT

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		Allocated from Home Office			1,640			6
7	TOTAL				\$ 1,640			7

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

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A N/A

9. Option to Buy: YES NO Terms: N/A *

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: \$ 17,832 Description: Copier - \$3160, Dishwasher - \$1730, Nursing Equip - \$12,083, Home Office - \$859

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ <u>N/A</u>	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

* 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.

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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>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.
- SEE ACCOUNTANTS' COMPILATION REPORT**

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

	Service	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, 1	2056	hrs	\$ 46,580					2,056	\$ 46,580	1
2	Licensed Speech and Language Development Therapist	10A, 1	158	hrs	5,222					158	5,222	2
3	Licensed Recreational Therapist			hrs								3
4	Licensed Physical Therapist	10A, 1&3	622	hrs	26,066	1	87			623	26,153	4
5	Physician Care			visits								5
6	Dental Care			visits								6
7	Work Related Program			hrs								7
8	Habilitation			hrs								8
9	Pharmacy	39, 2		# of prescripts				21,300			21,300	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10
11	Academic Education			hrs								11
12	Exceptional Care Program											12
13	Other (specify): <u>Resp. Therapy, Oxygen</u>	10A,3 & 39,2				1	104	23,760		1	23,864	13
14	TOTAL				\$ 77,868	2	\$ 191	\$ 45,060		2,838	\$ 123,119	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 1,652,730	\$ 1,652,730	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	882,379	882,379	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	12,104	12,104	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,547,213	\$ 2,547,213	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000	200,000	13
14	Buildings, at Historical Cost	1,578,657	1,634,342	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	630,763	607,809	16
17	Accumulated Depreciation (book methods)	(457,296)	(413,758)	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): <u>Security Deposit</u>	7,553	7,553	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,959,677	\$ 2,035,946	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,506,890	\$ 4,583,159	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 395,466	\$ 395,466	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,808	151,808	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,143	5,143	31
32	Accrued Real Estate Taxes(Sch.IX-B)	60,500	60,500	32
33	Accrued Interest Payable	13,322	13,322	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Expenses</u>	28,131	28,131	36
37	<u>Due To Related Party</u>	123,502	123,502	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 777,872	\$ 777,872	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	8,021	8,021	40
41	Bonds Payable	2,306,008	2,306,008	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,314,029	\$ 2,314,029	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,091,901	\$ 3,091,901	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,414,989	\$ 1,491,258	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,506,890	\$ 4,583,159	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 607,986	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustment	(26,837)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 581,149	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	833,840	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)	\$ 833,840	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)	\$ 1,414,989	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,751,855	1
2	Discounts and Allowances for all Levels	143,644	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,895,499	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	182,675	6
7	Oxygen	34,588	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 217,263	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants	44,700	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,209	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	94,972	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	31,786	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 173,667	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7,798	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,798	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Trans	326	28
28a	Misc Income	9,572	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,898	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,304,125	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,023,649	31
32	Health Care	1,925,912	32
33	General Administration	820,145	33
B. Capital Expense			
34	Ownership	380,561	34
C. Ancillary Expense			
35	Special Cost Centers	210,518	35
36	Provider Participation Fee	109,500	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,470,285	40
41	Income before Income Taxes (line 30 minus line 40)**	833,840	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 833,840	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	2,080	2,080	\$ 55,715	\$ 26.79	1
2	Assistant Director of Nursing	1,552	1,656	33,865	20.45	2
3	Registered Nurses	2,751	3,017	56,004	18.56	3
4	Licensed Practical Nurses	31,018	32,378	508,260	15.70	4
5	CNAs & Orderlies	76,472	78,324	735,665	9.39	5
6	CNA Trainees					6
7	Licensed Therapist	3,070	3,070	77,868	25.36	7
8	Rehab/Therapy Aides					8
9	Activity Director	3,732	3,908	37,726	9.65	9
10	Activity Assistants	5,306	5,494	45,654	8.31	10
11	Social Service Workers	5,677	5,725	74,602	13.03	11
12	Dietician					12
13	Food Service Supervisor	2,623	2,626	20,683	7.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,816	25,584	178,855	6.99	15
16	Dishwashers					16
17	Maintenance Workers	3,994	4,066	49,818	12.25	17
18	Housekeepers	17,740	18,327	121,365	6.62	18
19	Laundry	10,182	10,542	82,177	7.80	19
20	Administrator	2,080	2,080	95,583	45.95	20
21	Assistant Administrator	2,080	2,080		0.00	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	32,973	15.85	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,080	2,080	33,011	15.87	31
32	Other Health C: CPC	2,080	2,080	47,291	22.74	32
33	Other(specify) <u>Transportation</u>	5,018	5,400	43,130	7.99	33
34	TOTAL (lines 1 - 33)	206,431	212,597	\$ 2,330,245 *	\$ 10.96	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant			35	
36	Medical Director	Monthly	12,000	9, 3	36
37	Medical Records Consultant	1 Visit	147	10, 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	600	10, 3	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)		\$ 12,747		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Royal Oaks Care Center**

0046243

Report Period Beginning: **01/01/06**

Ending: **12/31/06**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Angie Ince	Administrator	0	\$ 51,247	Workers' Compensation Insurance	\$ 63,535	IDPH License Fee	\$ 589	
Deborah Richter	Assistant Admin	0	44,336	Unemployment Compensation Insurance	54,610	Advertising: Employee Recruitment	(870)	
				FICA Taxes	175,698	Health Care Worker Background Check (Indicate # of checks performed <u>356</u>)	3,560	
				Employee Health Insurance	114,326	Miscellaneous Dues & Subscriptions	678	
				Employee Meals	4,281	Allocated from Home Office	881	
				Illinois Municipal Retirement Fund (IMRF)*				
				401K Employee Retirement	1,201			
				Employee Relations	3,550			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 95,583	TOTAL (agree to Schedule V, line 22, col.8)		\$ 417,201	TOTAL (agree to Sch. V, line 20, col. 8)	
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 (Adjusted on Page 6)			\$ 170,000	N/A			Out-of-State Travel	\$ 0
							In-State Travel	0
							Seminar Expense	0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 170,000	TOTAL		\$	Allocated from Home Office	806
C. Professional Services							Entertainment Expense (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount				TOTAL	\$ 806
Altschuler, Melvoin & Glasser, LLP	Accounting		\$ 5,850					
RSM McGladrey	Accounting		1,075					
Lindon Engineering Services	Accounting		3,394					
Ivans	Computer Services		40					
LTC Solution, Inc	Computer Services		1,320					
Emdeon Business Services	Computer Services		235					
Ivans	Computer Services		51					
Ivans	Computer Services		51					
Network Business Systems, Inc.	Computer Services		314					
Insight Communications	Computer Services		249					
Insight Communications	Computer Services		121					
LTC Solution, Inc	Computer Services		1,320					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 14,020					

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2003	FY2004	FY2005	FY2006
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								
2																				
3							N/A													
4																				
5																				
6																				
7																				
8																				
9																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19																				
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$								

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

01/01/06

Ending:

12/31/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 8 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,112 Line 10, 2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (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. \$ 4,281 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,209
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- 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? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (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 \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees