

Facility Name & ID Number Royal Oaks Care Center

0046243 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	36,860	7,949	1,766	46,575	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	36,860	7,949	1,766	46,575	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 63.80%

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 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 1,766

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	197,398	28,792		226,190		226,190	3,897	230,087		1
2	Food Purchase		244,748		244,748		244,748	(2,717)	242,031		2
3	Housekeeping	113,614	28,943		142,557		142,557	44	142,601		3
4	Laundry	91,872	16,968		108,840		108,840	3	108,843		4
5	Heat and Other Utilities			204,787	204,787		204,787	666	205,453		5
6	Maintenance	51,843	23,504	28,169	103,516		103,516	6,518	110,034		6
7	Other (specify):* Home Off. Ben. All.							1,778	1,778		7
8	TOTAL General Services	454,727	342,955	232,956	1,030,638		1,030,638	10,189	1,040,827		8
	B. Health Care and Programs										
9	Medical Director			11,000	11,000		11,000		11,000		9
10	Nursing and Medical Records	1,318,328	82,430	18,238	1,418,996		1,418,996	10,046	1,429,042		10
10a	Therapy	98,993	373	611	99,977		99,977		99,977		10a
11	Activities	131,823	190	771	132,784		132,784	(841)	131,943		11
12	Social Services	69,243			69,243		69,243		69,243		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,291	2,291		15
16	TOTAL Health Care and Programs	1,618,387	82,993	30,620	1,732,000		1,732,000	11,496	1,743,496		16
	C. General Administration										
17	Administrative	88,241		200,000	288,241		288,241	(170,987)	117,254		17
18	Directors Fees										18
19	Professional Services			10,634	10,634		10,634	13,188	23,822		19
20	Dues, Fees, Subscriptions & Promotions			9,786	9,786		9,786	2,392	12,178		20
21	Clerical & General Office Expenses	34,280	9,829	12,344	56,453		56,453	78,944	135,397		21
22	Employee Benefits & Payroll Taxes			340,235	340,235		340,235	15,255	355,490		22
23	Inservice Training & Education			205	205		205	801	1,006		23
24	Travel and Seminar			230	230		230	1,271	1,501		24
25	Other Admin. Staff Transportation			15,388	15,388		15,388	7,296	22,684		25
26	Insurance-Prop.Liab.Malpractice			30,469	30,469		30,469	4,584	35,053		26
27	Other (specify):* Home Off. Ben. All.							18,889	18,889		27
28	TOTAL General Administration	122,521	9,829	619,291	751,641		751,641	(28,367)	723,274		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,195,635	435,777	882,867	3,514,279		3,514,279	(6,682)	3,507,597		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:

01/01/2007

Ending:

12/31/2007

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			140,341	140,341		140,341	27,876	168,217			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			158,560	158,560		158,560	35,015	193,575			32
33	Real Estate Taxes			69,560	69,560		69,560	1,524	71,084			33
34	Rent-Facility & Grounds							94	94			34
35	Rent-Equipment & Vehicles			15,091	15,091		15,091	1,265	16,356			35
36	Other (specify):*											36
37	TOTAL Ownership			383,552	383,552		383,552	65,774	449,326			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		61,017		61,017		61,017		61,017			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,500	109,500		109,500		109,500			42
43	Other (specify):* Non-allowable Cost		248	54,729	54,977		54,977	(54,977)				43
44	TOTAL Special Cost Centers		61,265	164,229	225,494		225,494	(54,977)	170,517			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,195,635	497,042	1,430,648	4,123,325		4,123,325	4,115	4,127,440			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.

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(2,852)	2		4
5	Telephone, TV & Radio in Resident Rooms	(931)	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	(3,742)	30		9
10	Interest and Other Investment Income	(202)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(973)	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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,714)	43		24
25	Fund Raising, Advertising and Promotional	(2,899)	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 Pg. 5A</u>	(19,254)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (64,567)		\$	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)	68,682	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 68,682		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 4,115		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

Royal Oaks Care Center

ID# 0046243

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (9,884)	43	1
2	X-Rays-Part A	(2,804)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(259)	10	3
4	Offset Transportation Revenue	(841)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(1,144)	21	5
6	Offset Chamber of Commerce Dues	(550)	20	6
7	Resident Flowers	(992)	43	7
8	Disallowed Special Events	(2,780)	43	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(19,254)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	3,897	0	0	0	0	0	0	0	0	0	3,897	1
2	Food Purchase	(2,852)	135	0	0	0	0	0	0	0	0	0	(2,717)	2
3	Housekeeping	0	44	0	0	0	0	0	0	0	0	0	44	3
4	Laundry	0	3	0	0	0	0	0	0	0	0	0	3	4
5	Heat and Other Utilities	0	666	0	0	0	0	0	0	0	0	0	666	5
6	Maintenance	0	5,429	0	1,089	0	0	0	0	0	0	0	6,518	6
7	Other (specify):*	0	1,778	0	0	0	0	0	0	0	0	0	1,778	7
8	TOTAL General Services	(2,852)	11,952	0	1,089	0	10,189	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	(259)	10,305	0	0	0	0	0	0	0	0	0	10,046	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(841)	0	0	0	0	0	0	0	0	0	0	(841)	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	2,291	0	0	0	0	0	0	0	0	0	2,291	15
16	TOTAL Health Care and Programs	(1,100)	12,596	0	0	0	0	0	0	0	0	0	11,496	16
	C. General Administration													
17	Administrative	0	(170,987)	0	0	0	0	0	0	0	0	0	(170,987)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,876	0	5,312	0	0	0	0	0	0	0	13,188	19
20	Fees, Subscriptions & Promotions	(550)	0	1,707	1,235	0	0	0	0	0	0	0	2,392	20
21	Clerical & General Office Expenses	(1,144)	0	66,064	14,024	0	0	0	0	0	0	0	78,944	21
22	Employee Benefits & Payroll Taxes	0	0	0	15,255	0	0	0	0	0	0	0	15,255	22
23	Inservice Training & Education	0	0	760	41	0	0	0	0	0	0	0	801	23
24	Travel and Seminar	0	0	1,209	62	0	0	0	0	0	0	0	1,271	24
25	Other Admin. Staff Transportation	0	0	4,381	2,915	0	0	0	0	0	0	0	7,296	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,784	2,800	0	0	0	0	0	0	0	4,584	26
27	Other (specify):*	0	0	18,889	0	0	0	0	0	0	0	0	18,889	27
28	TOTAL General Administration	(1,694)	(163,111)	94,794	41,644	0	(28,367)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(5,646)	(138,563)	94,794	42,733	0	(6,682)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(3,742)	0	4,626	26,992	0	0	0	0	0	0	0	27,876	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(202)	0	8,041	27,176	0	0	0	0	0	0	0	35,015	32
33	Real Estate Taxes	0	0	1,524	0	0	0	0	0	0	0	0	1,524	33
34	Rent-Facility & Grounds	0	0	94	0	0	0	0	0	0	0	0	94	34
35	Rent-Equipment & Vehicles	0	0	1,227	38	0	0	0	0	0	0	0	1,265	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(3,944)	0	15,512	54,206	0	65,774	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):*	(54,977)	0	0	0	0	0	0	0	0	0	0	(54,977)	43
44	TOTAL Special Cost Centers	(54,977)	0	0	0	0	0	0	0	0	0	0	(54,977)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(64,567)	(138,563)	110,306	96,939	0	4,115	45						

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	100	See Attached Schedule 6E		See Attached Sch 6E		

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%	\$ 3,897	\$ 3,897	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	135	135	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	44	44	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	666	666	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	5,429	5,429	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,778	1,778	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10,305	10,305	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%	2,291	2,291	10
11	V	17 Administrative	200,000	Petersen Health Care, Inc.	100.00%	29,013	(170,987)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,876	7,876	12
13	V							13
14	Total		\$ 200,000			\$ 61,437	\$ * (138,563)	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 and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,707	\$ 1,707
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	66,064	66,064
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	760	760
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,209	1,209
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,381	4,381
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,784	1,784
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	18,889	18,889
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,626	4,626
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	8,041	8,041
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,524	1,524
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	94	94
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,227	1,227
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 110,306	\$ * 110,306

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$ 0
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0	0
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0	0
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0	0
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0	0
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	1,089	1,089
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0	0
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0	0
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	5,312	5,312
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,235	1,235
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	14,024	14,024
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	15,255	15,255
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	41	41
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	62	62
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	2,915	2,915
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	2,800	2,800
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	26,992	26,992
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	27,176	27,176
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0	0
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0	0
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	38	38
39	Total		\$			\$ 96,939	\$ * 96,939

* 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:

01/01/2007

Ending: 2/31/2007

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	1,316,550	66	\$ 110,171	\$ 109,587	46,575	\$ 3,897	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	46,575	135	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	46,575	44	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	46,575	3	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	46,575	666	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	46,575	5,429	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	46,575	1,778	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	46,575	10,305	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	46,575	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	46,575	2,291	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	46,575	29,013	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	46,575	7,876	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	46,575	1,707	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	46,575	66,064	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	46,575	760	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	46,575	1,209	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	46,575	4,381	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	46,575	1,784	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	46,575	18,889	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	46,575	4,626	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	46,575	8,041	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	46,575	1,524	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	46,575	94	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	46,575	1,227	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 171,743	25

Facility Name & ID Number Royal Oaks Care Center# 0046243 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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	340,686	11	\$	46,575	\$	1
2	2	Food	Resident Days	340,686	11		46,575		2
3	3	Housekeeping	Resident Days	340,686	11		46,575		3
4	4	Laundry	Resident Days	340,686	11		46,575		4
5	5	Utilities	Resident Days	340,686	11		46,575		5
6	6	Maintenance	Resident Days	340,686	11	7,966	46,575	1,089	6
7	7	Mgmt. Allocation of Benefits	Resident Days	340,686	11		46,575		7
8	10	Nursing and Medical Records	Resident Days	340,686	11		46,575		8
9	15	Mgmt. Allocation of Benefits	Resident Days	340,686	11		46,575		9
10	17	Administrative	Resident Days	340,686	11		46,575		10
11	19	Professional Services	Resident Days	340,686	11	38,857	46,575	5,312	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	340,686	11	9,036	46,575	1,235	12
13	21	Clerical and General Office	Resident Days	340,686	11	102,581	46,575	14,024	13
14	22	Employee Benefits & Payroll	Resident Days	340,686	11	111,591	46,575	15,255	14
15	23	Inservice Training & Education	Resident Days	340,686	11	300	46,575	41	15
16	24	Travel and Seminar	Resident Days	340,686	11	451	46,575	62	16
17	25	Other Admin. Staff Transport.	Resident Days	340,686	11	21,324	46,575	2,915	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	340,686	11	20,484	46,575	2,800	18
19	27	Mgmt. Allocation of Benefits	Resident Days	340,686	11		46,575		19
20	30	Depreciation	Resident Days	340,686	11	197,442	46,575	26,992	20
21	32	Interest	Resident Days	340,686	11	198,787	46,575	27,176	21
22	33	Real Estate Taxes	Resident Days	340,686	11		46,575		22
23	34	Rent-Facility and Grounds	Resident Days	340,686	11		46,575		23
24	35	Rent-Equipment & Vehicles	Resident Days	340,686	11	280	46,575	38	24
25	TOTALS					\$ 709,099	\$	\$ 96,939	25

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 2,240,196	12/31/11	Varies	\$ 158,524	1					
2	Ford Credit		X	Van Purchase	\$541.00	04/17/03	30,965		Paid in 2007		36	2					
3							Offset Interest Income				(202)	3					
4							Home Office Allocation-PHC				8,041	4					
5							Home Office Allocation-PHC II				27,176	5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related				\$541.00		\$ 2,450,965	\$ 2,240,196			\$ 193,575	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	\$ 2,240,196			\$ 193,575	15					

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

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

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

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 2006 report.		\$	60,500	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.)	2006	\$	64,060	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,560	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	66,000	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			1,524	
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.		\$	71,084	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002	56,100	8	
	2003	58,874	9	
	2004	62,532	10	
	2005	61,246	11	
	2006	64,060	12	
Accrual based on prior year tax bill.				
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Royal Oaks Care Center COUNTY Henry

FACILITY IDPH LICENSE NUMBER 0046243

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>Long-Term Care Facility</u>	\$ <u>63,004.00</u>	\$ <u>63,004.00</u>
2. <u>25-03-401-009</u>	<u>Long-Term Care Facility</u>	\$ <u>1,056.00</u>	\$ <u>1,056.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>64,060.00</u>	\$ <u>64,060.00</u>

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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:

01/01/2007 Ending:

12/31/2007

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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</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

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	\$ 182,267	4
5										5
6										6
7	Home Office Allocation			25,966			634	634		7
8										8
	Improvement Type**									
9	Architectural Fees		2003	2,010		15	134	134	477	9
10	Water Softener		2003	14,625		7	2,089	2,089	7,591	10
11	Disposer		2003	1,231		7	176	176	629	11
12	Hot Water Heater		2003	5,892		7	842	842	2,863	12
13	Parking lot		2004	25,762		15	1,717	1,717	7,728	13
14	Service Road		2004	6,940		15	463	463	1,504	14
15	Sidewalk		2004	2,600		15	173	173	548	15
16	Air Conditioning		2004	5,101		25	204	204	639	16
17	Fire Alarm		2004	5,810		25	232	232	727	17
18	Security System		2004	1,206		7	172	172	525	18
19	Water Heater		2005	6,518		30	217	217	506	19
20	New Flooring		2005	5,440		10	544	544	1,133	20
21	New Roof		2005	22,002		30	733	733	1,466	21
22	New Heating and Air conditioning		2006	6,378		15	425	425	850	22
23	Driveway		2007	7,625		15	264	264	264	23
24	Sidewalk		2007	7,200		15	240	240	240	24
25	Fire Alarm		2007	1,398		10	70	70	70	25
26	Smoke Detectors		2007	4,400		10	220	220	220	26
27	Water Heater		2007	11,619		10	581	581	581	27
28										28
29										29
30										30
31	Building Booked				38,229			(38,229)		31
32	Building Improvement Booked				7,885			(7,885)		32
33										33
34										34
35	2007-Home Office Allocation-Building Improvements			1,737			103	103		35
36										36

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

See Page 12A, Line 70 for total

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

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)	\$ 1,661,555	\$ 46,114		\$ 48,441	\$ 2,327	\$ 210,828	70

**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	\$ 576,776	\$ 86,397	\$ 81,884	\$ (4,513)	7-8	\$ 310,306	71
72	Current Year Purchases	16,076	1,623	804	(819)	10	804	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			30,881	30,881			74
75	TOTALS	\$ 592,852	\$ 88,020	\$ 113,569	\$ 25,549		\$ 311,110	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	\$ 26,896	76
77										77
78										78
79										79
80	TOTALS			\$ 31,033	\$ 6,207	\$ 6,207	\$		\$ 26,896	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)	\$ 2,485,440	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 140,341	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 168,217	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 27,876	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 548,834	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		<u>Home Office Allocation</u>			<u>94</u>			6
7	TOTAL				\$ <u>94</u>			7

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

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

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

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: \$ 16,356 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

* 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 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 11,007
Dishwasher	1,112
Copier	2,972
Home Office Allocation	1,265
	<u>16,356</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	10A(3)	2339 hrs	\$ 49,255		\$		2,339	\$ 49,255	1	
2	Licensed Speech and Language Development Therapist	10A(3)	111 hrs	3,671				111	3,671	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(1), 10A(2), 10A(3)	2824 hrs	46,067			373	2,824	46,440	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				61,017		61,017	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>Respiratory Therapy</u>					41	611	41	611	13	
14	TOTAL			\$ 98,993		41	\$ 611	\$ 61,390	5,315	\$ 160,994	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: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(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	\$ 2,038,535	\$ 2,038,535	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,075,957	1,075,957	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,391	28,391	6
7	Other Prepaid Expenses	9,046	9,046	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,151,929	\$ 3,151,929	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	1,516,061	14
15	Leasehold Improvements, at Historical Cost	64,297	145,494	15
16	Equipment, at Historical Cost	646,839	623,885	16
17	Accumulated Depreciation (book methods)	(597,637)	(548,834)	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): <u> </u>			22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,853,722	\$ 1,936,606	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,005,651	\$ 5,088,535	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 304,338	\$ 304,338	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,313	156,313	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,512	9,512	31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,000	66,000	32
33	Accrued Interest Payable	13,049	13,049	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Paryoll Withholdings</u>	36,829	36,829	36
37	<u>Due to Related Parties</u>	55,713	55,713	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 641,754	\$ 641,754	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,240,196	2,240,196	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>A/P-Prior Owner</u>	12,804	12,804	43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,253,000	\$ 2,253,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,894,754	\$ 2,894,754	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,110,897	\$ 2,193,781	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,005,651	\$ 5,088,535	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,414,989	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(10,085)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,404,904	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	705,993	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)	\$ 705,993	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)	\$ 2,110,897	24 *

* This must agree with page 17, line 47.

Royal Oaks Care Center
0046243
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 18A

XVI. Statement of Changes in Equity

Beginning Equity Restatements:

Post Cost Report Audit Adjustments

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

**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	\$ 4,461,632	1
2	Discounts and Allowances for all Levels	88,262	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,549,894	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	156,933	6
7	Oxygen	373	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 157,306	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	2,852	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	90,189	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	24,531	20
21	Other Medical Services	2,100	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 119,672	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	202	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 202	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,403	28
28a	Transportation Revenue	841	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,244	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,829,318	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,030,638	31
32	Health Care	1,732,000	32
33	General Administration	751,641	33
	B. Capital Expense		
34	Ownership	383,552	34
	C. Ancillary Expense		
35	Special Cost Centers	115,994	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)*	\$ 4,123,325	40
41	Income before Income Taxes (line 30 minus line 40)**	705,993	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 705,993	43

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

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

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

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

Facility Name & ID Number Royal Oaks Care Center# 0046243Report Period Beginning: 01/01/2007Ending: 12/31/2007**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? Yes
If YES, give association name and amount. IHCA-\$3,750
- (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. \$ 9,827 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 109,500
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 2,852
- (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? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company 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 still 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 \$5,000, 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