

Facility Name & ID Number Royal Oaks Care Center

0046243 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	73,200	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	73,200	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	41,062	5,513	1,469	48,044	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	41,062	5,513	1,469	48,044	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 65.63%

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 1,469

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	219,053	29,038		248,091		248,091	8,540	256,631		1
2	Food Purchase		264,098		264,098		264,098	(1,866)	262,232		2
3	Housekeeping	112,055	35,782		147,837		147,837	63	147,900		3
4	Laundry	103,020	20,129		123,149		123,149	4	123,153		4
5	Heat and Other Utilities			245,645	245,645		245,645	885	246,530		5
6	Maintenance	53,714	15,542	24,247	93,503		93,503	7,417	100,920		6
7	Other (specify):* Home Off. Ben. All.							2,100	2,100		7
8	TOTAL General Services	487,842	364,589	269,892	1,122,323		1,122,323	17,143	1,139,466		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,513,379	97,006	3,365	1,613,750		1,613,750	11,731	1,625,481		10
10a	Therapy	99,798		35,807	135,605		135,605		135,605		10a
11	Activities	93,227	79	219	93,525		93,525	(3,168)	90,357		11
12	Social Services	85,437			85,437		85,437		85,437		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,588	2,588		15
16	TOTAL Health Care and Programs	1,791,841	97,085	51,391	1,940,317		1,940,317	11,151	1,951,468		16
	C. General Administration										
17	Administrative	61,400		251,000	312,400		312,400	(184,522)	127,878		17
18	Directors Fees										18
19	Professional Services			8,723	8,723		8,723	17,497	26,220		19
20	Dues, Fees, Subscriptions & Promotions			10,050	10,050		10,050	5,258	15,308		20
21	Clerical & General Office Expenses	66,360	8,639	13,727	88,726		88,726	95,372	184,098		21
22	Employee Benefits & Payroll Taxes			289,359	289,359		289,359	1,671	291,030		22
23	Inservice Training & Education			2,803	2,803		2,803	507	3,310		23
24	Travel and Seminar			1,070	1,070		1,070	696	1,766		24
25	Other Admin. Staff Transportation			22,901	22,901		22,901	10,862	33,763		25
26	Insurance-Prop.Liab.Malpractice			135,191	135,191		135,191	3,009	138,200		26
27	Other (specify):* Home Off. Ben. All.							23,750	23,750		27
28	TOTAL General Administration	127,760	8,639	734,824	871,223		871,223	(25,900)	845,323		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,407,443	470,313	1,056,107	3,933,863		3,933,863	2,394	3,936,257		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Royal Oaks Care Center

#0046243

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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			141,497	141,497		141,497	43,744	185,241			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			153,700	153,700		153,700	54,352	208,052			32
33	Real Estate Taxes			74,849	74,849		74,849	1,219	76,068			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,588	19,588		19,588	1,294	20,882			35
36	Other (specify):*											36
37	TOTAL Ownership			389,634	389,634		389,634	100,609	490,243			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,538		47,538		47,538		47,538			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,800	109,800		109,800		109,800			42
43	Other (specify):* Non-allowable Cost		898	44,727	45,625		45,625	(45,625)				43
44	TOTAL Special Cost Centers		48,436	154,527	202,963		202,963	(45,625)	157,338			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,407,443	518,749	1,600,268	4,526,460		4,526,460	57,378	4,583,838			45

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

Royal Oaks Care Center

ID# 0046243

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,143)	43	1
2	X-Rays-Part A	(1,313)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(3,090)	10	3
4	Offset Transportation Revenue	(3,168)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(952)	21	5
6	Offset Chamber of Commerce Dues	(605)	20	6
7	Resident Flowers	(141)	43	7
8	Disallowed Special Events	1	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	(11,411)		49

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%	\$ 8,540	\$ 8,540	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	140	140	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	63	63	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	4	4	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	885	885	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	5,219	5,219	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,100	2,100	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	14,821	14,821	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,588	2,588	10
11	V	17 Administrative	251,000	Petersen Health Care, Inc.	100.00%	66,478	(184,522)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	7,503	7,503	12
13	V							13
14	Total		\$ 251,000			\$ 108,341	\$ * (142,659)	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%	\$ 2,314	\$	2,314	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	83,424		83,424	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	507		507	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	508		508	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	6,568		6,568	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	400		400	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	23,750		23,750	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	9,089		9,089	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,393		6,393	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,219		1,219	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,039		1,039	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		\$			\$ 135,211	\$ *	135,211	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	2,198	2,198
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	9,994	9,994
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	3,549	3,549
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	12,900	12,900
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	1,671	1,671
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	188	188
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	4,294	4,294
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	2,609	2,609
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	34,312	34,312
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	48,331	48,331
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	255	255
39	Total		\$			\$ 120,301	\$ * 120,301

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

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	1,762,196	1.99	3.32	Salary	66,478	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	\$ 66,478		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Royal Oaks Care Center# 0046243 Report Period Beginning: 1/1/2008 Ending: 2/31/2008

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 W. Trailcreek Drive
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	48,044	\$ 8,540	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	48,044	140	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	48,044	63	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	48,044	4	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	48,044	885	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	48,044	5,219	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	48,044	2,100	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	48,044	14,821	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	48,044	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	48,044	2,588	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	48,044	66,478	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	48,044	7,503	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	48,044	2,314	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	48,044	83,424	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	48,044	507	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	48,044	508	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	48,044	6,568	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	48,044	400	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	48,044	23,750	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	48,044	9,089	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	48,044	6,393	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	48,044	1,219	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	48,044	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	48,044	1,039	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 243,552	25

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2008

Ending: 2/31/2008

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	331,413	13	\$	48,044	\$	1
2	2	Food	Resident Days	331,413	13		48,044		2
3	3	Housekeeping	Resident Days	331,413	13		48,044		3
4	4	Laundry	Resident Days	331,413	13		48,044		4
5	5	Utilities	Resident Days	331,413	13		48,044		5
6	6	Maintenance	Resident Days	331,413	13	15,163	48,044	2,198	6
7	7	Mgmt. Allocation of Benefits	Resident Days	331,413	13		48,044		7
8	10	Nursing and Medical Records	Resident Days	331,413	13		48,044		8
9	15	Mgmt. Allocation of Benefits	Resident Days	331,413	13		48,044		9
10	17	Administrative	Resident Days	331,413	13		48,044		10
11	19	Professional Services	Resident Days	331,413	13	68,939	48,044	9,994	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	331,413	13	24,482	48,044	3,549	12
13	21	Clerical and General Office	Resident Days	331,413	13	88,982	48,044	12,900	13
14	22	Employee Benefits & Payroll	Resident Days	331,413	13	11,527	48,044	1,671	14
15	23	Inservice Training & Education	Resident Days	331,413	13		48,044		15
16	24	Travel and Seminar	Resident Days	331,413	13	1,299	48,044	188	16
17	25	Other Admin. Staff Transport.	Resident Days	331,413	13	29,621	48,044	4,294	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	331,413	13	18,001	48,044	2,609	18
19	27	Mgmt. Allocation of Benefits	Resident Days	331,413	13		48,044		19
20	30	Depreciation	Resident Days	331,413	13	236,686	48,044	34,312	20
21	32	Interest	Resident Days	331,413	13	333,393	48,044	48,331	21
22	33	Real Estate Taxes	Resident Days	331,413	13		48,044		22
23	34	Rent-Facility and Grounds	Resident Days	331,413	13		48,044		23
24	35	Rent-Equipment & Vehicles	Resident Days	331,413	13	1,756	48,044	255	24
25	TOTALS					\$ 829,849	\$	\$ 120,301	25

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		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	\$ 2,169,628	12/31/11	Varies	\$ 153,700	1				
2												2				
3							Interest Income Offset				(372)	3				
4							Home Office Allocation-PHC				6,393	4				
5							Home Office Allocation-PHC II				48,331	5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 2,420,000	\$ 2,169,628			\$ 208,052	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 2,420,000	\$ 2,169,628			\$ 208,052	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 2007 report.		\$	66,000	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.)		\$	69,349	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,349	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	71,500	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			1,219	
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.		\$	76,068	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	58,874	8
	2004	62,532	9
	2005	61,246	10
	2006	64,060	11
	2007	69,349	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>68,206.30</u>	\$ <u>68,206.30</u>
2. <u>25-03-401-009</u>	<u>Long-Term Care Facility</u>	\$ <u>1,143.18</u>	\$ <u>1,143.18</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>69,349.48</u>	\$ <u>69,349.48</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,875 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

1/1/2008

Ending:

12/31/2008

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	\$ 220,475	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Architectural Fees		2003	2,010		15	134	134	611	9
10	Water Softener		2003	14,625		7	2,089	2,089	9,680	10
11	Disposer		2003	1,231		7	176	176	805	11
12	Hot Water Heater		2003	5,892		7	842	842	3,705	12
13	Parking lot		2004	25,762		15	1,717	1,717	9,445	13
14	Service Road		2004	6,940		15	463	463	1,967	14
15	Sidewalk		2004	2,600		15	173	173	721	15
16	Air Conditioning		2004	5,101		25	204	204	843	16
17	Fire Alarm		2004	5,810		25	232	232	959	17
18	Security System		2004	1,206		7	172	172	697	18
19	Water Heater		2005	6,518		30	217	217	723	19
20	New Flooring		2005	5,440		10	544	544	1,677	20
21	New Roof		2005	22,002		30	733	733	2,199	21
22	New Heating and Air conditioning		2006	6,378		15	425	425	1,275	22
23	Driveway		2007	7,625		15	508	508	772	23
24	Sidewalk		2007	7,200		15	480	480	720	24
25	Fire Alarm		2007	1,398		10	140	140	210	25
26	Smoke Detectors		2007	4,400		10	440	440	660	26
27	Water Heater		2007	11,619		10	1,162	1,162	1,743	27
28	Water Storage Tank		2008	5,647		5	565	565	565	28
29	Rooftop Heating Unit		2008	27,573		5	2,757	2,757	2,757	29
30	Roof		2008	72,265		39	926	926	926	30
31	Roof Repairs		2008	5,673		39	73	73	73	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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			38,229			(38,229)		39
40			12,181			(12,181)		40
41								41
42		24,946			598	598		42
43		1,669			108	108		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		\$ 1,771,625	\$ 50,410		\$ 54,086	\$ 3,676	\$ 264,208	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	\$ 592,852	\$ 87,895	\$ 83,492	\$ (4,403)	7-10 yrs.	\$ 394,602	71
72	Current Year Purchases	2,500	89	125	36	10	125	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			43,401	43,401			74
75	TOTALS	\$ 595,352	\$ 87,984	\$ 127,018	\$ 39,034		\$ 394,727	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	\$ 3,103	\$ 4,137	\$ 1,034	5	\$ 31,033	76
77										77
78										78
79										79
80	TOTALS			\$ 31,033	\$ 3,103	\$ 4,137	\$ 1,034		\$ 31,033	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,598,010	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 141,497	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 185,241	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 43,744	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 689,968	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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: \$ 20,882 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Royal Oaks Care Center

0046243

Period Beginning

1/1/2008

Period End

12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 15,721
Dishwasher	900
Copier	2,967
Home Office Allocation	1,294
	<u>20,882</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	820	hrs	\$ 49,180	68	\$ 1,024	\$	888	\$ 50,204	1
2	Licensed Speech and Language Development Therapist	10A(3)	24	hrs	1,465	556	8,347		580	9,812	2
3	Licensed Recreational Therapist			hrs		67	1,000		67	1,000	3
4	Licensed Physical Therapist	10A(3)	819	hrs	49,153	1,696	25,436		2,515	74,589	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				47,538		47,538	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): _____										12
13	Other (specify): _____										13
14	TOTAL				\$ 99,798	2,387	\$ 35,807	\$ 47,538	4,050	\$ 183,143	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ 2,620,225	\$ 2,620,225	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,172,969	1,172,969	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	49,526	49,526	6
7	Other Prepaid Expenses	20,591	20,591	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,863,311	\$ 3,863,311	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	1,515,041	14
15	Leasehold Improvements, at Historical Cost	175,455	256,584	15
16	Equipment, at Historical Cost	649,339	626,385	16
17	Accumulated Depreciation (book methods)	(739,133)	(689,968)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,825,884	\$ 1,908,042	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,689,195	\$ 5,771,353	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 608,221	\$ 608,221	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	156,970	156,970	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,403	7,403	31
32	Accrued Real Estate Taxes(Sch.IX-B)	71,500	71,500	32
33	Accrued Interest Payable	12,103	12,103	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Paryoll Withholdings</u>	39,255	39,255	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 895,452	\$ 895,452	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,169,628	2,169,628	40
41	Bonds Payable			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)	\$ 2,169,628	\$ 2,169,628	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,065,080	\$ 3,065,080	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,624,115	\$ 2,706,273	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,689,195	\$ 5,771,353	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,110,897	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,110,900	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	513,215	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)	\$ 513,215	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)	\$ 2,624,115	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,750,991	1
2	Discounts and Allowances for all Levels	75,131	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,826,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	120,557	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 120,557	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	2,006	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	79,522	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	2,056	20
21	Other Medical Services	1,830	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 85,414	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	372	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 372	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	4,042	28
28a	Transportation Revenue	3,168	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,210	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,039,675	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,122,323	31
32	Health Care	1,940,317	32
33	General Administration	871,223	33
	B. Capital Expense		
34	Ownership	389,634	34
	C. Ancillary Expense		
35	Special Cost Centers	93,163	35
36	Provider Participation Fee	109,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,526,460	40
41	Income before Income Taxes (line 30 minus line 40)**	513,215	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 513,215	43

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

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

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

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

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	\$ 55,854	\$ 26.85	1
2	Assistant Director of Nursing	1,676	1,716	29,999	17.48	2
3	Registered Nurses	2,810	2,882	33,466	11.61	3
4	Licensed Practical Nurses	26,608	28,377	491,546	17.32	4
5	CNAs & Orderlies	83,780	86,305	807,091	9.35	5
6	CNA Trainees					6
7	Licensed Therapist	5,236	5,441	99,797	18.34	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	21,054	10.12	9
10	Activity Assistants	2,869	2,942	27,650	9.40	10
11	Social Service Workers	7,550	7,646	85,437	11.17	11
12	Dietician					12
13	Food Service Supervisor	2,480	2,568	31,759	12.37	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,588	23,951	187,294	7.82	15
16	Dishwashers					16
17	Maintenance Workers	3,854	3,926	53,714	13.68	17
18	Housekeepers	13,321	14,221	112,055	7.88	18
19	Laundry	11,026	11,669	103,020	8.83	19
20	Administrator	2,080	2,080	61,400	29.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,711	4,967	66,360	13.36	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	1,532	1,578	17,756	11.25	31
32	Other Health C: Care Plan Coord.	3,950	4,007	77,667	19.38	32
33	Other(specify) <u>Transportation</u>	3,818	3,938	44,523	11.31	33
34	TOTAL (lines 1 - 33)	205,049	212,374	\$ 2,407,442 *	\$ 11.34	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			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,270	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)	\$ 13,270		49

C. CONTRACT NURSES

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

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	
<u>Angela Ince</u>	<u>Administrator</u>	<u>0</u>	\$ <u>61,400</u>	<u>Workers' Compensation Insurance</u>	\$ <u>49,397</u>	<u>IDPH License Fee</u>	\$ _____	
_____	_____	_____	_____	<u>Unemployment Compensation Insurance</u>	<u>46,085</u>	<u>Advertising: Employee Recruitment</u>	_____	
_____	_____	_____	_____	<u>FICA Taxes</u>	<u>181,438</u>	<u>Health Care Worker Background Check</u>	_____	
_____	_____	_____	_____	<u>Employee Health Insurance</u>	<u>8,939</u>	(Indicate # of checks performed _____)	_____	
_____	_____	_____	_____	<u>Employee Meals</u>	_____	<u>Patient Background Checks</u>	<u>284</u> <u>2,840</u>	
_____	_____	_____	_____	<u>Illinois Municipal Retirement Fund (IMRF)*</u>	_____	<u>Miscellaneous Licenses & Permits</u>	<u>735</u>	
_____	_____	_____	_____	<u>Employee Relations</u>	<u>3,781</u>	<u>Miscellaneous Dues & Subscriptions</u>	<u>605</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ <u>61,400</u>	<u>Employee Retirement</u>	<u>1,213</u>	<u>IHCA Dues</u>	<u>5,870</u>	
(List each licensed administrator separately.)				<u>Employee Life Insurance</u>	<u>177</u>	<u>Home Office Allocation</u>	<u>5,863</u>	
				_____	_____	_____	_____	
				_____	_____	Less: Public Relations Expense	(605)	
				_____	_____	Non-allowable advertising	(_____)	
				_____	_____	Yellow page advertising	(_____)	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ <u>291,030</u>	TOTAL (agree to Sch. V, line 20, col. 8)	\$ <u>15,308</u>	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Description	Amount	
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			\$ <u>251,000</u>	_____	_____	<u>Out-of-State Travel</u>	\$ _____	
_____			_____	_____	_____	_____	_____	
_____			_____	_____	_____	<u>In-State Travel</u>	_____	
_____			_____	_____	_____	_____	_____	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ <u>251,000</u>	<u>N/A</u>	_____	_____	_____	
(Attach a copy of any management service agreement)				_____	_____	<u>Seminar Expense</u>	<u>1,070</u>	
C. Professional Services								
Vendor/Payee	Type			Amount				
<u>Insight Communications</u>	<u>Computer Services</u>			\$ <u>121</u>				
<u>E-Health Data Solutions</u>	<u>Computer Services</u>			<u>4,200</u>				
<u>Comcast</u>	<u>Computer Services</u>			<u>1,320</u>				
<u>LTC Solutions</u>	<u>Computer Services</u>			<u>1,600</u>				
<u>Farnsworth Group</u>	<u>Architectural Services</u>			<u>1,482</u>				
_____	_____			_____				
_____	_____			_____				
_____	_____			_____				
_____	_____			_____				
_____	_____			_____				
TOTAL (agree to Schedule V, line 19, column 3)			\$ <u>8,723</u>	TOTAL	\$ _____	<u>Home Office Allocation</u>	<u>696</u>	
(If total legal fees exceed \$5,000, attach copy of invoices.)				_____	_____	<u>Entertainment Expense</u>	(_____)	
				_____	_____	TOTAL (agree to Sch. V, line 24, col. 8)	\$ <u>1,766</u>	

* Attach copy of IMRF notifications

**See instructions.

Royal Oaks Care Center

0046243

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,723

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	273
GoffWilson, P.A.	Legal	911
U.S. Bank	Legal	1,589
Ginoli & Company	Accountants	8,005
RSM McGladrey	Accountants	21
U.S. Bank	Accountants	975
Miscellaneous Vendors	Computer Services	106
Emdeon Business Services	Computer Services	147
Advanced Answers on Demand	Computer Services	1,724
Access 2 Go	Computer Services	509
Ivans	Computer Services	1,416
Kemper Technology	Computer Services	933
VisionShare	Computer Services	100
Logmeln	Computer Services	72
Comm Net Communiations	Computer Services	26
Charter Communications	Computer Services	22
Advanced System Designs	Computer Services	33
Consolidated Communications	Computer Services	20
CDW	Computer Services	485
Miscellaneous Vendors	Miscellaneous	130

Total (agree to Schedule V, line 19, column 8)	<u>26,220</u>
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Royal Oaks Care Center

0046243

Period Beginning

1/1/2008

Period End

12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

<u>Name</u>	<u>Function</u>	<u>Ownership %</u>	<u>Amount</u>
Angela Ince	Administrator	0	61,400
	Total		<u>61,400</u>

Facility Name & ID Number Royal Oaks Care Center# 0046243Report Period Beginning: 1/1/2008Ending: 12/31/2008**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. 5,870 -IHCA
- (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? No
- (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. \$ 10,537 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? N/A
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. \$ 109,800
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. \$ 2,006
- (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. \$ No
- 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? N/A
- 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? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (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 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 \$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