

Facility Name & ID Number Royal Oaks Care Center

0046243 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	48,849	4,766	1,912	55,527	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,849	4,766	1,912	55,527	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.06%

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 3/1/2003

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

YES Date 3/1/2003 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 200 and days of care provided 1,880

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: 12/31/2009 Fiscal Year: 12/31/2009

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

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	224,885	34,024		258,909		258,909	9,711	268,620		1
2	Food Purchase		296,767		296,767		296,767	(1,708)	295,059		2
3	Housekeeping	121,111	45,526		166,637		166,637	91	166,728		3
4	Laundry	101,547	19,644		121,191		121,191		121,191		4
5	Heat and Other Utilities			223,295	223,295		223,295	959	224,254		5
6	Maintenance	55,156	19,758	35,034	109,948		109,948	4,806	114,754		6
7	Other (specify):* Home Off. Ben. All.							1,753	1,753		7
8	TOTAL General Services	502,699	415,719	258,329	1,176,747		1,176,747	15,612	1,192,359		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,792,476	132,959	13,929	1,939,364		1,939,364	5,877	1,945,241		10
10a	Therapy	85,018		86,164	171,182		171,182		171,182		10a
11	Activities	100,408	213	322	100,943		100,943	(194)	100,749		11
12	Social Services	90,885	152		91,037		91,037		91,037		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							724	724		15
16	TOTAL Health Care and Programs	2,068,787	133,324	112,415	2,314,526		2,314,526	6,407	2,320,933		16
	C. General Administration										
17	Administrative	30,000		396,000	426,000		426,000	(331,387)	94,613		17
18	Directors Fees										18
19	Professional Services			27,700	27,700		27,700	36,573	64,273		19
20	Dues, Fees, Subscriptions & Promotions			7,583	7,583		7,583	5,946	13,529		20
21	Clerical & General Office Expenses	97,679	10,210	16,622	124,511		124,511	116,210	240,721		21
22	Employee Benefits & Payroll Taxes			353,555	353,555		353,555	14,253	367,808		22
23	Inservice Training & Education			25	25		25	1,417	1,442		23
24	Travel and Seminar							312	312		24
25	Other Admin. Staff Transportation			22,736	22,736		22,736	12,026	34,762		25
26	Insurance-Prop.Liab.Malpractice			69,273	69,273		69,273	2,024	71,297		26
27	Other (specify):* Home Off. Ben. All.							26,578	26,578		27
28	TOTAL General Administration	127,679	10,210	893,494	1,031,383		1,031,383	(116,048)	915,335		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,699,165	559,253	1,264,238	4,522,656		4,522,656	(94,029)	4,428,627		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:

1/1/2009

Ending:

12/31/2009

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			144,242	144,242		144,242	55,984	200,226			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			150,546	150,546		150,546	61,199	211,745			32
33	Real Estate Taxes			65,677	65,677		65,677	1,230	66,907			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,895	21,895		21,895	1,181	23,076			35
36	Other (specify):*											36
37	TOTAL Ownership			382,360	382,360		382,360	119,594	501,954			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		74,799		74,799		74,799		74,799			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		261	134,784	135,045		135,045	(135,045)				43
44	TOTAL Special Cost Centers		75,060	244,284	319,344		319,344	(135,045)	184,299			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,699,165	634,313	1,890,882	5,224,360		5,224,360	(109,480)	5,114,880			45

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

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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	(1,926)	2		4
5	Telephone, TV & Radio in Resident Rooms	(582)	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	(355)	30		9
10	Interest and Other Investment Income	(84)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(101)	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	(538)	43		18
19	Entertainment				19
20	Contributions	(50)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(94,640)	43		24
25	Fund Raising, Advertising and Promotional	(2,051)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(38,442)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (138,769)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	29,289	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 29,289		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (109,480)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Royal Oaks Care Center

ID# 0046243

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (29,993)	43	1
2	X-Rays-Part A	(4,363)	43	2
3	Disallowed Special Events	(2,600)	43	3
4	Offset Transportation Revenue	(194)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(515)	21	5
6	Offset Chamber of Commerce Dues	(650)	20	6
7	Resident Flowers	(127)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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		(38,442)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	9,711	0	0	0	0	0	0	0	0	0	9,711	1
2	Food Purchase	(1,926)	218	0	0	0	0	0	0	0	0	0	(1,708)	2
3	Housekeeping	0	91	0	0	0	0	0	0	0	0	0	91	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	959	0	0	0	0	0	0	0	0	0	959	5
6	Maintenance	0	4,703	0	103	0	0	0	0	0	0	0	4,806	6
7	Other (specify):*	0	1,753	0	0	0	0	0	0	0	0	0	1,753	7
8	TOTAL General Services	(1,926)	17,435	0	103	0	15,612	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,877	0	0	0	0	0	0	0	0	0	5,877	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(194)	0	0	0	0	0	0	0	0	0	0	(194)	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	724	0	0	0	0	0	0	0	0	0	724	15
16	TOTAL Health Care and Programs	(194)	6,601	0	0	0	0	0	0	0	0	0	6,407	16
	C. General Administration													
17	Administrative	0	(331,387)	0	0	0	0	0	0	0	0	0	(331,387)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,615	0	22,958	0	0	0	0	0	0	0	36,573	19
20	Fees, Subscriptions & Promotions	(650)	0	3,794	2,802	0	0	0	0	0	0	0	5,946	20
21	Clerical & General Office Expenses	(515)	0	99,016	17,709	0	0	0	0	0	0	0	116,210	21
22	Employee Benefits & Payroll Taxes	0	0	0	14,253	0	0	0	0	0	0	0	14,253	22
23	Inservice Training & Education	0	0	1,011	406	0	0	0	0	0	0	0	1,417	23
24	Travel and Seminar	0	0	312	0	0	0	0	0	0	0	0	312	24
25	Other Admin. Staff Transportation	0	0	4,879	7,147	0	0	0	0	0	0	0	12,026	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,024	0	0	0	0	0	0	0	0	2,024	26
27	Other (specify):*	0	0	26,578	0	0	0	0	0	0	0	0	26,578	27
28	TOTAL General Administration	(1,165)	(317,772)	137,614	65,275	0	(116,048)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,285)	(293,736)	137,614	65,378	0	(94,029)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(355)	0	8,003	48,336	0	0	0	0	0	0	0	55,984	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(84)	0	12,309	48,974	0	0	0	0	0	0	0	61,199	32
33	Real Estate Taxes	0	0	1,230	0	0	0	0	0	0	0	0	1,230	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	1,177	4	0	0	0	0	0	0	0	1,181	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(439)	0	22,719	97,314	0	119,594	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):*	(135,045)	0	0	0	0	0	0	0	0	0	0	(135,045)	43
44	TOTAL Special Cost Centers	(135,045)	0	0	0	0	0	0	0	0	0	0	(135,045)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(138,769)	(293,736)	160,333	162,692	0	0	0	0	0	0	0	(109,480)	45

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 9,711	\$ 9,711	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	218	218	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	91	91	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	959	959	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,703	4,703	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,753	1,753	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,877	5,877	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%	724	724	10
11	V	17 Administrative	396,000	Petersen Health Care, Inc.	100.00%	64,613	(331,387)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	13,615	13,615	12
13	V							13
14	Total		\$ 396,000			\$ 102,264	\$ * (293,736)	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%	\$ 3,794	\$	3,794	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	99,016		99,016	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	1,011		1,011	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	312		312	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,879		4,879	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	2,024		2,024	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	26,578		26,578	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	8,003		8,003	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	12,309		12,309	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,230		1,230	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%	1,177		1,177	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		\$			\$ 160,333	\$ *	160,333	39

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

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	103		103 20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	22,958		22,958 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	2,802		2,802 26
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	17,709		17,709 27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	14,253		14,253 28
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	406		406 29
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	7,147		7,147 31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	48,336		48,336 34
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	48,974		48,974 35
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	4		4 38
39	Total		\$			\$ 162,692	\$ *	162,692 39

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	153,278	2	3.33	Salary	\$ 5,835	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	\$ 5,835		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:

1/1/2009

Ending: 2/31/2009

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	1,493,044	75	\$ 261,102	\$ 259,584	55,527	\$ 9,711	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	55,527	218	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	55,527	91	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	55,527	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	55,527	959	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	55,527	4,703	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	55,527	1,753	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	55,527	5,877	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	55,527	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	55,527	724	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	55,527	64,613	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	55,527	13,615	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	55,527	3,794	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	55,527	99,016	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	55,527	1,011	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	55,527	312	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	55,527	4,879	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	55,527	2,024	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	55,527	26,578	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	55,527	8,003	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	55,527	12,309	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	55,527	1,230	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	55,527	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	55,527	1,177	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 262,597	25

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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	336,837	13		55,527		1
2	2	Food	Resident Days	336,837	13		55,527		2
3	3	Housekeeping	Resident Days	336,837	13		55,527		3
4	4	Laundry	Resident Days	336,837	13		55,527		4
5	5	Utilities	Resident Days	336,837	13		55,527		5
6	6	Maintenance	Resident Days	336,837	13	628	55,527	103	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,837	13		55,527		7
8	10	Nursing and Medical Records	Resident Days	336,837	13		55,527		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,837	13		55,527		9
10	17	Administrative	Resident Days	336,837	13		55,527		10
11	19	Professional Services	Resident Days	336,837	13	139,269	55,527	22,958	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,837	13	17,001	55,527	2,802	12
13	21	Clerical and General Office	Resident Days	336,837	13	107,426	55,527	17,709	13
14	22	Employee Benefits & Payroll	Resident Days	336,837	13	86,458	55,527	14,253	14
15	23	Inservice Training & Education	Resident Days	336,837	13	2,464	55,527	406	15
16	24	Travel and Seminar	Resident Days	336,837	13		55,527		16
17	25	Other Admin. Staff Transport.	Resident Days	336,837	13	43,354	55,527	7,147	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,837	13		55,527		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,837	13		55,527		19
20	30	Depreciation	Resident Days	336,837	13	293,215	55,527	48,336	20
21	32	Interest	Resident Days	336,837	13	297,084	55,527	48,974	21
22	33	Real Estate Taxes	Resident Days	336,837	13		55,527		22
23	34	Rent-Facility and Grounds	Resident Days	336,837	13		55,527		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,837	13	26	55,527	4	24
25	TOTALS					\$ 986,925	\$	\$ 162,692	25

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
	A. Directly Facility Related															
	Long-Term															
1	U S Bank		X	Mortgage	Varies	08/31/02	\$ 2,420,000	\$ 2,093,958	12/31/11	Varies	\$ 150,546	1				
2												2				
3							Interest Income Offset				(84)	3				
4							Home Office Allocation-PHC				12,309	4				
5							Home Office Allocation-PHC II				48,974	5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 2,420,000	\$ 2,093,958			\$ 211,745	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	\$ 2,093,958			\$ 211,745	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

1. Real Estate Tax accrual used on 2008 report.		\$	71,500	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.)	2008	\$	67,577	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(3,923)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	69,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	1,230	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	66,907	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004	62,532	8
	2005	61,246	9
	2006	64,060	10
	2007	69,349	11
	2008	67,577	12

Accrual based on prior year tax bill.				

			FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2008	\$		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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>67,576.26</u>	\$ <u>67,576.26</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 and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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:

1/1/2009 Ending:

12/31/2009

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>	1
2					2
3	TOTALS	362,419		\$ 200,000	3

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	\$ 258,683	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Architectural Fees	2003		2,010		15	134	134	745	9
10		Water Softener	2003		14,625		7	2,089	2,089	11,769	10
11		Disposer	2003		1,231		7	176	176	981	11
12		Hot Water Heater	2003		5,892		7	842	842	4,547	12
13		Parking lot	2004		25,762		15	1,717	1,717	11,162	13
14		Service Road	2004		6,940		15	463	463	2,430	14
15		Sidewalk	2004		2,600		15	173	173	894	15
16		Air Conditioning	2004		5,101		25	204	204	1,047	16
17		Fire Alarm	2004		5,810		25	232	232	1,191	17
18		Security System	2004		1,206		7	172	172	869	18
19		Water Heater	2005		6,518		30	217	217	940	19
20		New Flooring	2005		5,440		10	544	544	2,221	20
21		New Roof	2005		22,002		30	733	733	2,932	21
22		New Heating and Air conditioning	2006		6,378		15	425	425	1,700	22
23		Driveway	2007		7,625		15	508	508	1,280	23
24		Sidewalk	2007		7,200		15	480	480	1,200	24
25		Fire Alarm	2007		1,398		10	140	140	350	25
26		Smoke Detectors	2007		4,400		10	440	440	1,100	26
27		Water Heater	2007		11,619		10	1,162	1,162	2,905	27
28		Water Storage Tank	2008		5,647		5	1,130	1,130	1,695	28
29		Rooftop Heating Unit	2008		27,573		5	5,514	5,514	8,271	29
30		Roof	2008		72,265		39	1,852	1,852	2,778	30
31		Roof Repairs	2008		5,673		39	146	146	219	31
32		Water Heater	2009		3,240		5	324	324	324	32
33		Rooftop Cooling Unit	2009		13,500		5	1,350	1,350	1,350	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

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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			4,359			(4,359)		51
52			38,229			(38,229)		52
53			13,915			(13,915)		53
54								54
55								55
56		1,826			115	115		56
57		27,297			655	655		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		\$ 1,790,873	\$ 56,503		\$ 60,145	\$ 3,642	\$ 323,583	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	\$ 595,352	\$ 87,739	\$ 83,742	\$ (3,997)	7-10 yrs.	\$ 478,469	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			56,339	56,339			74
75	TOTALS	\$ 595,352	\$ 87,739	\$ 140,081	\$ 52,342		\$ 478,469	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	\$		\$	5	\$ 31,033	76
77										77
78										78
79										79
80	TOTALS			\$ 31,033	\$	\$	\$		\$ 31,033	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,617,258	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 144,242	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 200,226	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 55,984	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 833,085	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 23,076 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Royal Oaks Care Center

0046243

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 19,073
Dishwasher	900
Copier	1,922
Home Office Allocation	1,181
	<u>23,076</u>

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2009 Ending: 12/31/2009
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	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(1)&10A(3)	2163	hrs	\$ 44,964	968	\$ 14,513	\$	3,131	\$ 59,477	1
2	Licensed Speech and Language Development Therapist	10A(3)		hrs		820	12,293		820	12,293	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A(1) & 10A(3)	2787	hrs	40,054	3,902	58,528		6,689	98,582	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39(2)		# of prescrpts				74,799		74,799	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify): <u>Respiratory Therapy</u>					55	830		55	830	13
14	TOTAL				\$ 85,018	5,745	\$ 86,164	\$ 74,799	10,695	\$ 245,981	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# 0046243Report Period Beginning: 1/1/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(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	\$ 3,348,407	\$ 3,348,407	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,602,995	1,602,995	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	101,421	101,421	6
7	Other Prepaid Expenses	25,167	25,167	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,077,990	\$ 5,077,990	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	1,517,392	14
15	Leasehold Improvements, at Historical Cost	192,195	273,481	15
16	Equipment, at Historical Cost	649,339	626,385	16
17	Accumulated Depreciation (book methods)	(883,376)	(833,085)	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)	\$ 1,698,381	\$ 1,784,173	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,776,371	\$ 6,862,163	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 593,856	\$ 593,856	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	162,539	162,539	30
31	Accrued Taxes Payable (excluding real estate taxes)	6,817	6,817	31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,600	69,600	32
33	Accrued Interest Payable	13,187	13,187	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	121,833	121,833	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 967,832	\$ 967,832	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,093,958	2,093,958	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>A/P-Prior Owner</u>	6,017	6,017	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,099,975	\$ 2,099,975	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,067,807	\$ 3,067,807	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,708,564	\$ 3,794,356	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,776,371	\$ 6,862,163	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,624,115	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,624,116	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,084,448	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)	\$ 1,084,448	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)	\$ 3,708,564	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Royal Oaks Care Center# 0046243Report Period Beginning: 1/1/2009Ending: 12/31/2009

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	\$ 6,008,496	1
2	Discounts and Allowances for all Levels	(102,127)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,906,369	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	249,187	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 249,187	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	1,926	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	139,100	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,123	20
21	Other Medical Services	2,310	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 152,459	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	84	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 84	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	194	28
28a	Transportation Revenue	515	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 709	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,308,808	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,176,747	31
32	Health Care	2,314,526	32
33	General Administration	1,031,383	33
B. Capital Expense			
34	Ownership	382,360	34
C. Ancillary Expense			
35	Special Cost Centers	209,844	35
36	Provider Participation Fee	109,500	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,224,360	40
41	Income before Income Taxes (line 30 minus line 40)**	1,084,448	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,084,448	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 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

0046243

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	\$ 60,613	\$ 29.14	1
2	Assistant Director of Nursing	1,581	1,581	39,175	24.78	2
3	Registered Nurses	4,596	4,748	102,925	21.68	3
4	Licensed Practical Nurses	30,337	31,499	561,140	17.81	4
5	CNAs & Orderlies	98,878	101,853	941,624	9.24	5
6	CNA Trainees					6
7	Licensed Therapist	31	31	1,550	50.00	7
8	Rehab/Therapy Aides	4,727	4,919	83,468	16.97	8
9	Activity Director	2,080	2,080	19,969	9.60	9
10	Activity Assistants	2,735	2,919	29,273	10.03	10
11	Social Service Workers	7899	8,119	90,885	11.19	11
12	Dietician					12
13	Food Service Supervisor	3,922	3,992	42,566	10.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,258	22,725	182,319	8.02	15
16	Dishwashers					16
17	Maintenance Workers	3,856	3,957	55,156	13.94	17
18	Housekeepers	14,644	15,317	121,111	7.91	18
19	Laundry	10,955	11,520	101,547	8.81	19
20	Administrator	2,080	2,080	88,300	42.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	6,271	6,439	97,679	15.17	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,083	2,114	25,642	12.13	31
32	Other Health C: Care Plan Coord.	3,124	3,326	61,357	18.45	32
33	Other(specify) <u>Transportation</u>	4,394	4,706	51,166	10.87	33
34	TOTAL (lines 1 - 33)	228,531	236,005	\$ 2,757,465 *	\$ 11.68	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 1,260	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)	\$ 13,260		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	335 \$ 12,209	10(3)	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	335 \$ 12,209		53

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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	
Angela Ince	Administrator	0	\$ 88,300	Workers' Compensation Insurance	\$ 94,326	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	45,868	Advertising: Employee Recruitment	12	
				FICA Taxes	203,244	Health Care Worker Background Check		
				Employee Health Insurance	8,289	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	295 2,950	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	481	
				Employee Relations	15,527	Miscellaneous Dues & Subscriptions	650	
				Employee Retirement	554	IHCA Dues	1,500	
						Home Office Allocation	6,596	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 88,300			Less: Public Relations Expense	(650)	
(List each licensed administrator separately.)						Non-allowable advertising	()	
						Yellow page advertising	()	
B. Administrative - Other								
Description			Amount					
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 396,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 396,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 367,808	
(Attach a copy of any management service agreement)							TOTAL (agree to Sch. V, line 20, col. 8) \$ 13,529	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
SimpleLTC, Inc.	Computer Services		\$ 81				Out-of-State Travel	\$
E-Health Data Solutions	Computer Services		4,200					
Comcast	Computer Services		1,445					
LTC Solutions	Computer Services		1,700	N/A			In-State Travel	
Heyl, Royster, Voelker & Allen	Legal Services		20,209					
Bureau County Sheriff's Office	Legal Services		65					
							Seminar Expense	
							Home Office Allocation	312
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$ 27,700	TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)							TOTAL \$ 312	

* Attach copy of IMRF notifications

**See instructions.

Royal Oaks Care Center

0046243

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		27,700

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	87
GoffWilson, P.A.	Legal	124
Jackson Lewis	Legal	976
Peter Gartelos	Legal	95
Misc.	Legal	84
Ginoli & Company	Accountants	6,442
Miscellaneous Vendors	Computer Services	90
Emdeon Business Services	Computer Services	41
Advanced Answers on Demand	Computer Services	5,231
Access 2 Go	Computer Services	503
Ivans	Computer Services	312
Kemper Technology	Computer Services	1,422
VisionShare	Computer Services	443
MediFax	Computer Services	180
Logmein	Computer Services	78
Charter Communications	Computer Services	4
CDW	Computer Services	793
Simple LTC	Computer Services	1,207
Polaris Group	Other Professional Services	17,337
Donna Howard & Assoc.	Other Professional Services	297
Miscellaneous Vendors	Miscellaneous	827
Total (agree to Schedule V, line 19, column 8)		<u>64,273</u>

Royal Oaks Care Center

0046243

Period Beginning

1/1/2009

Period End

12/31/2009

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Heyl, Royster, Voelker, & Allen	2,678.81	100%	2,679
Heyl, Royster, Voelker, & Allen	3,028.20	100%	3,028
Heyl, Royster, Voelker, & Allen	8,352.06	100%	8,352
Heyl, Royster, Voelker, & Allen	5,432.30	100%	5,432
Heyl, Royster, Voelker, & Allen	69.00	100%	69
Heyl, Royster, Voelker, & Allen	414.00	100%	414
Heyl, Royster, Voelker, & Allen	234.20	100%	234
Bureau County Sheriff's Office	65.00	100%	65

Home Office Allocation

Heyl, Royster, Voelker, and Allen	2,414.77	3.62%	87
GoffWilson	3,425.00	3.62%	124
Jackson Lewis	27,043.20	3.62%	976
Peter Gartelos	2,612.50	3.62%	95
Miscellaneous Vendors	2,327.62	3.62%	84

Total Legal Fees

21,640

Facility Name & ID Number Royal Oaks Care Center# 0046243Report Period Beginning: 1/1/2009Ending: 12/31/2009**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. 1,500 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. \$ 11,074 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. \$ 109,500
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. \$ 1,926
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.