

		FOR BHF USE					

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**2017**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2017)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p><b>I. IDPH License ID Number:</b> <u>0046243</u></p> <p><b>Facility Name:</b> <u>Royal Oaks Care Center</u></p> <p><b>Address:</b> <u>605 East Church Street</u> <u>Kewanee</u> <u>61443</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>Henry</u></p> <p><b>Telephone Number:</b> <u>(309) 852-3389</u> <b>Fax #</b> <u>(309) 853-1838</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>03/01/2003</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust            IRS Exemption Code _____         </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input checked="" type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Mike Kocher</u> <b>Telephone Number:</b> <u>(309) 689-5850</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2017</u> to <u>12/31/2017</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">           (Signed) _____            (Type or Print Name) <u>Mark B. Petersen</u>            (Title) <u>Chief Executive Officer</u> </td> </tr> <tr> <td style="padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">           (Signed) _____            (Print Name and Title) _____            (Firm Name &amp; Address) _____            (Telephone) <u>( )</u> Fax # <u>( )</u> </td> </tr> </table> <p align="right"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # (217) 782-1630     </p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input checked="" type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Mark B. Petersen</u> (Title) <u>Chief Executive Officer</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> Fax # <u>( )</u>							

Facility Name & ID Number Royal Oaks Care Center

# 0046243 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	40,770	1,981	1,335	44,086	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,770	1,981	1,335	44,086	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.39%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 3/1/2003

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 200 and days of care provided 1,114

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: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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
	<b>A. General Services</b>										
1	Dietary	241,846	47,338		289,184		289,184	9,897	299,081		1
2	Food Purchase		284,812		284,812		284,812	(1,953)	282,859		2
3	Housekeeping	197,984	48,867		246,851		246,851	149	247,000		3
4	Laundry	80,626	17,678		98,304		98,304		98,304		4
5	Heat and Other Utilities			165,576	165,576		165,576	520	166,096		5
6	Maintenance	67,276	7,574	21,683	96,533		96,533	4,677	101,210		6
7	Other (specify):* Home Office Ben. Allocation										7
8	<b>TOTAL General Services</b>	587,732	406,269	187,259	1,181,260		1,181,260	13,290	1,194,550		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	2,043,077	150,764	14,837	2,208,678		2,208,678	(713)	2,207,965		10
10a	Therapy		67	231,936	232,003		232,003		232,003		10a
11	Activities	126,567	183	166	126,916		126,916	(6,978)	119,938		11
12	Social Services	60,038	11		60,049		60,049		60,049		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	<b>TOTAL Health Care and Programs</b>	2,229,682	151,025	258,939	2,639,646		2,639,646	(7,691)	2,631,955		16
	<b>C. General Administration</b>										
17	Administrative			392,400	392,400		392,400	(347,241)	45,159		17
18	Directors Fees										18
19	Professional Services			7,717	7,717		7,717	159,578	167,295		19
20	Dues, Fees, Subscriptions & Promotions			6,896	6,896		6,896	(319)	6,577		20
21	Clerical & General Office Expenses	80,701	6,487	25,529	112,717		112,717	106,156	218,873		21
22	Employee Benefits & Payroll Taxes			359,784	359,784		359,784	47,912	407,696		22
23	Inservice Training & Education			3,164	3,164		3,164	296	3,460		23
24	Travel and Seminar							147	147		24
25	Other Admin. Staff Transportation			21,633	21,633		21,633	7,093	28,726		25
26	Insurance-Prop.Liab.Malpractice			64,248	64,248		64,248	1,879	66,127		26
27	Other (specify):* Home Office Ben. Allocation										27
28	<b>TOTAL General Administration</b>	80,701	6,487	881,371	968,559		968,559	(24,499)	944,060		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,898,115	563,781	1,327,569	4,789,465		4,789,465	(18,900)	4,770,565		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 &amp; ID Number

Royal Oaks Care Center

#0046243

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## 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	
	<b>D. Ownership</b>											
30	Depreciation			95,961	95,961		95,961	21,306	117,267			30
31	Amortization of Pre-Op. & Org.							4,466	4,466			31
32	Interest			144,749	144,749		144,749	69,247	213,996			32
33	Real Estate Taxes			72,897	72,897		72,897	568	73,465			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			62,450	62,450		62,450	3,007	65,457			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			376,057	376,057		376,057	98,594	474,651			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		33,066		33,066		33,066		33,066			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			368,144	368,144		368,144		368,144			42
43	Other (specify):*		408	135,951	136,359		136,359	(136,359)				43
44	<b>TOTAL Special Cost Centers</b>		33,474	504,095	537,569		537,569	(136,359)	401,210			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,898,115	597,255	2,207,721	5,703,091		5,703,091	(56,665)	5,646,426			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: 1/1/2017

Ending: 12/31/2017

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,986)	43	1
2	X-Rays-Part A	(1,536)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(363)	21	3
4	Vending Machine Expense	(3,758)	43	4
5	Disallowed Special Events	(408)	43	5
6	Offset Transportation Revenue	(6,978)	11	6
7	Disallowed Chamber of Commerce Dues	(550)	20	7
8	Offset Miscellaneous Office Supplies Revenue	(851)	10	8
9				9
10				10
11				11
12				12
13				13
14				14
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(17,430)		49

Facility Name & ID Number

Royal Oaks Care Center

# 0046243

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1	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)	
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 9,897	\$ 9,897	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	43	43	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	149	149	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	520	520	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	4,677	4,677	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	138	138	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	392,400	Petersen Health Care Management, Inc.	100.00%	45,159	(347,241)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	30,995	30,995	12
13	V							13
14	Total		\$ 392,400			\$ 91,578	\$ * (300,822)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 231	\$	231	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	106,519		106,519	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	47,912		47,912	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	296		296	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	147		147	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	7,093		7,093	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,879		1,879	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	25,367		25,367	22
23	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	229		229	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	825		825	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	568		568	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	3,007		3,007	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		\$			\$ 194,073	\$ *	194,073	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, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Care II, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Care II, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Care II, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Care II, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Care II, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Care II, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Care II, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Care II, LLC	100.00%	128,583	128,583	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, LLC	100.00%	0		26
27	V	21 Clerical and General Office		Petersen Health Care II, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Care II, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Care II, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Care II, LLC	100.00%	1,270	1,270	33
34	V	31 Amortization		Petersen Health Care II, LLC	100.00%	4,237	4,237	34
35	V	32 Interest		Petersen Health Care II, LLC	100.00%	69,040	69,040	35
36	V	33 Real Estate Taxes		Petersen Health Care II, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, LLC	100.00%	0		38
39	Total		\$			\$ 203,130	\$ * 203,130	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health System	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30



Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Royal Oaks Care Center

# 0046243

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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 Management, 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	1,451,714	75	\$ 325,901	\$ 376,129	44,086	\$ 9,897	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	44,086	43	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	44,086	149	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	44,086	520	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	44,086	4,677	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	44,086	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	44,086	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	44,086	138	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	44,086	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	44,086	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	44,086	45,159	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	44,086	30,995	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	44,086	231	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	44,086	106,519	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	44,086	47,912	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	44,086	296	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	44,086	147	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	44,086	7,093	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	44,086	1,879	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	44,086	25,367	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	44,086	229	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	44,086	825	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	44,086	568	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	44,086	3,007	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 285,651	25

Facility Name & ID Number Royal Oaks Care Center

# 0046243

Report Period Beginning:

1/1/2017

Ending: 2/31/2017

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 II, LLC  
 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	150,571	6	\$	\$	44,086	\$	1
2	2	Food	Resident Days	150,571	6			44,086		2
3	3	Housekeeping	Resident Days	150,571	6			44,086		3
4	4	Laundry	Resident Days	150,571	6			44,086		4
5	5	Utilities	Resident Days	150,571	6			44,086		5
6	6	Maintenance	Resident Days	150,571	6			44,086		6
7	7	Mgmt. Allocation of Benefits	Resident Days	150,571	6			44,086		7
8	10	Nursing and Medical Records	Resident Days	150,571	6			44,086		8
9	15	Mgmt. Allocation of Benefits	Resident Days	150,571	6			44,086		9
10	17	Administrative	Resident Days	150,571	6			44,086		10
11	19	Professional Services	Resident Days	150,571	6	439,163		44,086	128,583	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	150,571	6			44,086		12
13	21	Clerical and General Office	Resident Days	150,571	6			44,086		13
14	22	Employee Benefits & Payroll	Resident Days	150,571	6			44,086		14
15	23	Inservice Training & Education	Resident Days	150,571	6			44,086		15
16	24	Travel and Seminar	Resident Days	150,571	6			44,086		16
17	25	Other Admin. Staff Transport.	Resident Days	150,571	6			44,086		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	150,571	6			44,086		18
19	30	Depreciation	Resident Days	150,571	6	4,339		44,086	1,270	19
20	31	Amortization	Resident Days	150,571	6	14,472		44,086	4,237	20
21	32	Interest	Resident Days	150,571	6	235,798		44,086	69,040	21
22	33	Real Estate Taxes	Resident Days	150,571	6			44,086		22
23	34	Rent-Facility and Grounds	Resident Days	150,571	6			44,086		23
24	35	Rent-Equipment & Vehicles	Resident Days	150,571	6			44,086		24
25	TOTALS					\$ 693,772	\$		\$ 203,130	25

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Royal Oaks Care Center

# 0046243

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**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Huntington Bank		X	Mortgage	Varies	2/1/17	\$ 3,337,200	\$ 2,761,807	1/31/37	Varies	\$ 144,638	1						
2	First Merit		X	Construction Loan	Varies	5/1/13	400,000	Paid	02/28/2017	Varies	111	2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 3,737,200	\$ 2,761,807			\$ 144,749	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income Offset		(618)	10						
11									Home Office Allocation-PHCM		825	11						
12									Home Office Allocation-PHC II		69,040	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 69,247	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 3,737,200	\$ 2,761,807			\$ 213,996	15						

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





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# 0046243

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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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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? [X] YES [ ] NO If so, please complete the following:

1. Total Amount Incurred: 799,059 2. Number of Years Over Which it is Being Amortized: 20 3. Current Period Amortization: 4,466 4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 362,419, 2003, \$ 200,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 362,419, (blank), \$ 200,000, 3.

Facility Name &amp; ID Number Royal Oaks Care Center

# 0046243

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**XI. OWNERSHIP COSTS (continued)****B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	200		2003	1998	\$ 1,926,596	\$	39	\$ 49,400	\$ 34,053	\$ 586,731	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Water Softener		2003		14,625		7			14,625	9
10	Service Road		2004		6,940		15	463	463	6,134	10
11	Sidewalk		2004		2,600		15	173	173	2,278	11
12	Air Conditioning		2004		5,101		25	204	204	2,679	12
13	Fire Alarm		2004		5,810		25	232	232	3,047	13
14	Security System		2004		1,206		7			1,206	14
15	New Flooring		2005		5,440		10			5,440	15
16	New Heating and Air conditioning		2006		6,378		15	425	425	5,100	16
17	Driveway		2007		7,625		15	508	508	5,344	17
18	Sidewalk		2007		7,200		15	480	480	5,040	18
19	Smoke Detectors		2007		4,400		10	440	440	4,180	19
20	Rooftop Heating Unit		2008		27,573		5			27,573	20
21	Rooftop Cooling Unit		2009		13,500		5			13,500	21
22	Water Pipe Repair		2011		5,544		7	792	792	5,148	22
23	Sprinkler System		2012		159,900		25	6,396	6,396	35,178	23
24	Carpeting-Lobby and Main Area		2013		31,230		15	2,082	2,082	9,369	24
25	Roof Replacement		2013		155,855		25	6,234	6,234	28,053	25
26	Flooring-Dining Hall		2013		12,409		15	428	428	2,126	26
27	Furnace Replacement		2014		124,562		25	4,983	4,983	17,441	27
28	Vinyl Tile & Carpet Installation in Hallways, Common Areas		2014		28,272		15	1,885	1,885	6,977	28
29	Nurses Station		2014		37,675		15	2,512	2,512	13,505	29
30	Water Heater		2014		4,734		7	676	676	2,366	30
31	Heat Pump		2014		7,566		25	303	303	1,061	31
32	Water Heater		2015		4,015		7	574	574	1,435	32
33	Air Conditioner		2016		2,518		7	360	360	540	33
34	Exterior Landscaping		2016		11,437		7	1,634	1,634	2,451	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 and Improvement Costs-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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60			2,833			(2,833)	
61			38,229			(38,229)	
62			44,565			(44,565)	
63							
64		20,166			484	484	
65		1,855			120	120	
66							
67							
68							
69							
70		\$ 2,642,732	\$ 85,627		\$ 81,788	\$ (19,186)	\$ 808,527

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

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XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 103,122	\$ 9,501	\$ 10,001	\$ 500	5-10 yrs.	\$ 62,197	71
72	Current Year Purchases	10,000	833	715	(118)	7 yrs.	715	72
73	Fully Depreciated Assets	599,730					599,730	73
74	Home Office Allocation			24,763	24,763			74
75	TOTALS	\$ 712,852	\$ 10,334	\$ 35,479	\$ 25,145		\$ 662,642	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2003 Ford Van	2003	\$ 31,033	\$	\$	\$		\$ 31,033	76
77										77
78										78
79										79
80	TOTALS			\$ 31,033	\$	\$	\$		\$ 31,033	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,586,617	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 95,961	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 117,267	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 21,306	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,502,202	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					88
89	N/A				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.

Facility Name & ID Number Royal Oaks Care Center

# 0046243

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Ending: 12/31/2017

**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	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2019 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2020 \$ \_\_\_\_\_

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: \$ 65,457

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					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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 1/1/2017**

**Period End 12/31/2017**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$ 58,164
Dishwasher	701
Copier	3,585
Home Office Allocation	3,007
	<u>65,457</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>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			
		1	2	3	4
		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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,507	\$ 97,602	\$	6,507	\$ 97,602	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,136	17,046		1,136	17,046	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,819	117,288	67	7,819	117,355	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				33,066		33,066	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	<b>TOTAL</b>			\$	15,462	\$ 231,936	\$ 33,133	15,462	\$ 265,069	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.

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of **12/31/2017**

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 5,847,949	\$ 5,847,949	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>102,080</u> )	1,573,361	1,573,361	3
4	Supply Inventory (priced at <u>Cost</u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	43,274	43,274	6
7	Other Prepaid Expenses	25,167	25,167	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Prepaid Expenses</u>	398,071	398,071	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 7,887,822	\$ 7,887,822	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000	200,000	13
14	Buildings, at Historical Cost	1,490,095	1,946,762	14
15	Leasehold Improvements, at Historical Cost	954,623	695,970	15
16	Equipment, at Historical Cost	743,885	743,885	16
17	Accumulated Depreciation (book methods)	(1,610,766)	(1,502,202)	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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,777,837	\$ 2,084,415	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 9,665,659	\$ 9,972,237	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,107,010	\$ 1,107,010	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,130	169,130	30
31	Accrued Taxes Payable (excluding real estate taxes)	256,042	256,042	31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,228	75,228	32
33	Accrued Interest Payable	13,168	13,168	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	2,563	2,563	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,623,141	\$ 1,623,141	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,761,807	2,761,807	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,761,807	\$ 2,761,807	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,384,948	\$ 4,384,948	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 5,280,711	\$ 5,587,289	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 9,665,659	\$ 9,972,237	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>4,758,704</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustments Made After Cost Report Was Filed</b>	<b>12,062</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>4,770,766</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>509,945</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>509,945</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>5,280,711</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Royal Oaks Care Center

# 0046243

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

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

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

1

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,938,533	1
2	Discounts and Allowances for all Levels	(200,684)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,737,849	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	409,940	6
7	Oxygen	1,075	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 411,015	8
<b>C. Other Operating Revenue</b>			
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	1,996	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	47,730	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,351	20
21	Other Medical Services	(1,007)	21
22	Laundry	292	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 55,362	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	618	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 618	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	6,978	28
28a	<u>Miscellaneous Revenue</u>	1,214	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,192	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,213,036	30

2

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,181,260	31
32	Health Care	2,639,646	32
33	General Administration	968,559	33
<b>B. Capital Expense</b>			
34	Ownership	376,057	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	169,425	35
36	Provider Participation Fee	368,144	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,703,091	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	509,945	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 509,945	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 5,207,525	44
45	Private Pay - Net Inpatient Revenue	258,089	45
46	Medicare - Net Inpatient Revenue	212,583	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	59,652	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 5,737,849	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

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

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

Facility Name & ID Number Royal Oaks Care Center

# 0046243

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	1,678	1,742	\$ 42,517	\$ 24.41	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,653	4,681	117,978	25.20	3
4	Licensed Practical Nurses	27,507	28,660	636,311	22.20	4
5	CNAs & Orderlies	89,004	93,176	1,012,210	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,945	2,017	24,486	12.14	9
10	Activity Assistants	4,290	4,453	40,663	9.13	10
11	Social Service Workers	4,139	4,163	60,038	14.42	11
12	Dietician					12
13	Food Service Supervisor	1,965	2,016	27,473	13.63	13
14	Head Cook					14
15	Cook Helpers/Assistants	24,369	24,713	214,373	8.67	15
16	Dishwashers					16
17	Maintenance Workers	3,661	3,805	67,276	17.68	17
18	Housekeepers	18,951	20,158	197,984	9.82	18
19	Laundry	7,590	7,990	80,626	10.09	19
20	Administrator	2,080	2,080	45,159	21.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,136	4,136	80,701	19.51	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	1,182	1,182	12,107	10.24	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	14,003	14,378	283,372	19.71	33
34	TOTAL (lines 1 - 33)	211,153	219,350	\$ 2,943,274 *	\$ 13.42	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	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 10,911	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 22,911		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	21 \$ 612	L10, C3	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	21 \$ 612		53

Royal Oaks Care Center

0046243

Period Beginning 1/1/2017

Period End 12/31/2017

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	6,782	6,926	192,650	27.82
Psych. Assistant	1,827	1,903	29,304	15.40
Transportation	5,394	5,549	61,418	11.07
<b>TOTAL</b>	<b>14,003</b>	<b>14,378</b>	<b>283,372</b>	

**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	
Linda Verway	Administrator	0	\$ 45,159	Workers' Compensation Insurance	\$ 70,101	IDPH License Fee	\$ 1,990	
				Unemployment Compensation Insurance	69,448	Advertising: Employee Recruitment	111	
				FICA Taxes	219,635	Health Care Worker Background Check (Indicate # of checks performed <u>297</u> )	2,409	
				Employee Health Insurance	(325)	Miscellaneous Licenses & Permits	839	
				Employee Meals		Miscellaneous Dues & Subscriptions	1,547	
				Illinois Municipal Retirement Fund (IMRF)*		Home Office Allocation	231	
				Employee Relations	354			
				Employee Retirement	571			
				Home Office Allocation	47,912			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 45,159	TOTAL (agree to Schedule V, line 22, col.8)		\$ 6,577		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(550)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 392,400				Non-allowable advertising ( )	
							Yellow page advertising ( )	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 392,400				TOTAL (agree to Sch. V, line 20, col. 8)	
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
First Midwest Bank	Legal Fees		\$ 91				Out-of-State Travel	\$
Comcast	Computer Services		1,499					
Ability Network	Computer Services		6,127				In-State Travel	
				N/A				
							Seminar Expense	
							Home Office Allocation	147
							Entertainment Expense ( )	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 7,717	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	

\* Attach copy of IMRF notifications

\*\*See instructions.

**Royal Oaks Care Center****0046243****Period Beginning****1/1/2017****Period End****12/31/2017****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		7,717
<b>Home Office Allocation</b>		
MusilloUnkenholt, LLC	Legal	353
Arnstein & Lehr	Legal	2380
SB2	Legal	1496
Miscellaneous	Legal	28
Miller Hall and Triggs	Legal	379
Smith Amundsen	Legal	147
Healthcare Resources International	Legal	262
Hunziker Law	Legal	2
Lexis Nexis	Legal	15
Baker Tilly Virchow Krause	Legal	1328
Huntington Bank	Legal	13006
CliftonLarsonAllen	Accounting	15832
Ginoli & Co.	Accounting	6518
Baker Tilly Virchow Krause	Accounting	265
Miscellaneous	Computer Services	196
Change Healthcare	Computer Services	16
360 Networks	Computer Services	81
Matrix Care	Computer Services	7418
Stratus Networks	Computer Services	886
Kemper Technology	Computer Services	503
AT&T	Computer Services	13
Ability Network	Computer Services	546
CIAN	Computer Services	617
Comcast	Computer Services	34
CCH	Computer Services	30
Charter Communications	Computer Services	62
Allscripts	Computer Services	549
ATS	Computer Services	564
Citrix Systems	Computer Services	52
Optimizer	Other Prof Fees	99
Ankura	Other Prof Fees	1597
David Budde	Other Prof Fees	74
Sargent Consulting	Other Prof Fees	52367
Alix Partners	Other Prof Fees	43755
Demonica Kemper	Other Prof Fees	66
Brad Barkley	Other Prof Fees	261
MPAC Healthcare	Other Prof Fees	39
Higgs Appraisal	Other Prof Fees	18
Alan Litwiller	Other Prof Fees	7
Total (agree to Schedule V, line 19, column 8)		<u>159,578</u>

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$952
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 38,062 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 368,144  
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. \$ 1,996
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 6,978  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees