

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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.

I. IDPH License ID Number: <u>0056481</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Royal Oaks Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
Address: <u>605 E Church St B600</u> <u>Kewanee</u> <u>61443</u>			
Number City Zip Code			
County: <u>Henry</u>			
Telephone Number: <u>(309) 852-3389</u> Fax # <u>(309) 853-1838</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>03/01/2003</u>			
Type of Ownership:			
☐ VOLUNTARY, NON-PROFIT		☒ PROPRIETARY	
☐ Charitable Corp.		☐ Individual	
☐ Trust		☐ Partnership	
IRS Exemption Code _____		☐ Corporation	
		☐ "Sub-S" Corp.	
		☒ Limited Liability Co.	
		☐ Trust	
		☐ Other _____	
In the event there are further questions about this report, please contact:			
Name: <u>Mike Kocher</u>		Telephone Number: <u>(309) 689-5850</u>	
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) <u>Mark Petersen</u>	
		(Title) <u>Chief Executive Officer</u>	
		Paid Preparer	
		(Signed) _____ (Date) _____	
		(Print Name and Title) _____	
		(Firm Name & Address) _____	
		(Telephone) <u>()</u> Fax # <u>()</u>	
		MAIL TO: BUREAU OF HEALTH FINANCE	
		ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES	
		201 S. Grand Avenue East	
		Springfield, IL 62763-0001	
		Phone # (217) 782-1630	

Facility Name & ID Number Royal Oaks Care Center

0056481 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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
2			Skilled Pediatric (SNF/PED)				
3			Intermediate (ICF)				
4			Intermediate/DD				
5			Sheltered Care (SC)				
6			ICF/DD 16 or Less				
7	200		TOTALS		200		73,000

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	40,382	2,377	1,503	44,262	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,382	2,377	1,503	44,262	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.63%

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

1,366

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: 12/31/2020

Fiscal Year: 12/31/2020

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

Facility Name & ID Number Royal Oaks Care Center # 0056481 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	232,844	47,141		279,985		279,985	11,750	291,735			1
2	Food Purchase		304,521		304,521		304,521	(1,389)	303,132			2
3	Housekeeping	213,689	61,787		275,476		275,476	227	275,703			3
4	Laundry	87,557	15,846		103,403		103,403		103,403			4
5	Heat and Other Utilities			151,787	151,787		151,787	802	152,589			5
6	Maintenance	68,264	7,099	36,291	111,654		111,654	7,057	118,711			6
7	Other (specify):*											7
8	TOTAL General Services	602,354	436,394	188,078	1,226,826		1,226,826	18,447	1,245,273			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,459,417	183,815	18,743	2,661,975		2,661,975	3,451	2,665,426			10
10a	Therapy			181,150	181,150		181,150		181,150			10a
11	Activities	114,060	1,039		115,099		115,099	273	115,372			11
12	Social Services	101,912			101,912		101,912		101,912			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,675,389	184,854	211,893	3,072,136		3,072,136	3,724	3,075,860			16
	C. General Administration											
17	Administrative	87,754		384,500	472,254		472,254	(319,155)	153,099			17
18	Directors Fees											18
19	Professional Services			11,175	11,175		11,175	559,465	570,640			19
20	Dues, Fees, Subscriptions & Promotions			5,319	5,319		5,319	5,415	10,734			20
21	Clerical & General Office Expenses	77,216	9,755	17,879	104,850		104,850	72,766	177,616			21
22	Employee Benefits & Payroll Taxes			368,295	368,295		368,295	20,351	388,646			22
23	Inservice Training & Education							121	121			23
24	Travel and Seminar							38	38			24
25	Other Admin. Staff Transportation			7,706	7,706		7,706	8,418	16,124			25
26	Insurance-Prop.Liab.Malpractice			104,939	104,939		104,939	1,283	106,222			26
27	Other (specify):*											27
28	TOTAL General Administration	164,970	9,755	899,813	1,074,538		1,074,538	348,702	1,423,240			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,442,713	631,003	1,299,784	5,373,500		5,373,500	370,873	5,744,373			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 #0056481 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			11,360	11,360		11,360	103,601	114,961			30
31	Amortization of Pre-Op. & Org.							176,536	176,536			31
32	Interest			22,925	22,925		22,925	718,261	741,186			32
33	Real Estate Taxes			76,326	76,326		76,326	463	76,789			33
34	Rent-Facility & Grounds			1,169,882	1,169,882		1,169,882	(1,169,882)				34
35	Rent-Equipment & Vehicles			28,670	28,670		28,670	195,106	223,776			35
36	Other (specify):*											36
37	TOTAL Ownership			1,309,163	1,309,163		1,309,163	24,085	1,333,248			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		49,983		49,983		49,983		49,983			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			364,740	364,740		364,740		364,740			42
43	Other (specify):*		19	53,908	53,927		53,927	(53,927)				43
44	TOTAL Special Cost Centers		50,002	418,648	468,650		468,650	(53,927)	414,723			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,442,713	681,005	3,027,595	7,151,313		7,151,313	341,031	7,492,344			45

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

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,389)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,999)	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	(973)	30		9
10	Interest and Other Investment Income	(4,953)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(183)	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	(27,589)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,000)	43		24
25	Fund Raising, Advertising and Promotional	(930)	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	(17,895)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (70,911)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 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)	411,942	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 411,942		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 341,031		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 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (6,619)	43	1
2	X-Rays-Part A	(1,987)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(88)	21	3
4	Disallowed Special Events	380	43	4
5	Offset Transportation Revenue	273	11	5
6	Disallowed Chamber of Commerce Dues	(600)	20	6
7	Offset Miscellaneous Nursing Supplies Revenue	(9,254)	10	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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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	(17,895)		49

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%	\$ 11,749	\$ 11,749	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	227	227	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	802	802	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	7,057	7,057	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%	11,010	11,010	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	384,500	Petersen Health Care Management, Inc.	100.00%	65,345	(319,155)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	38,597	38,597	12
13	V								13
14	Total			\$ 384,500			\$ 134,787	\$ * (249,713)	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%	\$ 6,015	\$ 6,015	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	72,855	72,855	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	20,000	20,000	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	121	121	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	38	38	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	8,418	8,418	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,283	1,283	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	11,894	11,894	22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	579	579	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	463	463	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	4,266	4,266	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			\$			\$ 125,932	\$ * 125,932	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%	\$	\$	15
16	V	2	Food		Petersen Health Care II, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Care II, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Care II, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Care II, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Care II, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Care II, LLC	100.00%	1,695	1,695	22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Care II, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Care II, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Care II, LLC	100.00%	520,868	520,868	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care II, LLC	100.00%			26
27	V	21	Clerical and General Office		Petersen Health Care II, LLC	100.00%			27
28	V	22	Employee Benefits & Payroll		Petersen Health Care II, LLC	100.00%	351	351	28
29	V	23	Inservice Training & Education		Petersen Health Care II, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Care II, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care II, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care II, LLC	100.00%			32
33	V	30	Depreciation		Petersen Health Care II, LLC	100.00%	776	776	33
34	V	31	Amortization		Petersen Health Care II, LLC	100.00%			34
35	V	32	Interest		Petersen Health Care II, LLC	100.00%	12,034	12,034	35
36	V	33	Real Estate Taxes		Petersen Health Care II, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Care II, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care II, LLC	100.00%	190,840	190,840	38
39	Total			\$			\$ 726,564	\$ * 726,564	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	6	Maintenance	\$	Royal Oaks Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	Royal Oaks Land, LLC	100.00%			16
17	V	21	Equipment		Royal Oaks Land, LLC	100.00%			17
18	V	26	Insurance-Property		Royal Oaks Land, LLC	100.00%			18
19	V	26	Insurance-Mortgage Insurance		Royal Oaks Land, LLC	100.00%			19
20	V	30	Depreciation		Royal Oaks Land, LLC	100.00%	91,904	91,904	20
21	V	31	Amortization		Royal Oaks Land, LLC	100.00%	176,536	176,536	21
22	V	32	Interest		Royal Oaks Land, LLC	100.00%	710,601	710,601	22
23	V	33	Real Estate Taxes		Royal Oaks Land, LLC	100.00%			23
24	V	34	Rent-Income and Grounds	1,169,882	Royal Oaks Land, LLC	100.00%		(1,169,882)	24
25	V								25
26	V								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			\$ 1,169,882			\$ 979,041	\$ * (190,841)	39

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

Facility Name & ID Number

Royal Oaks Care Center

0056481

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Syste	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 I	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 Busin	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

Facility Name & ID Number

Royal Oaks Care Center

0056481

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

Facility Name & ID Number

Royal Oaks Care Center

0056481

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

0056481

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Royal Oaks Care Center # 0056481 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	N/A										3
4											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# 0056481

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 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

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 341,556	\$ 398,718	44,262	\$ 11,749	1
2	2	Food	Resident Days	75	0	0	44,262	0	2
3	3	Housekeeping	Resident Days	75	6,605	3,056	44,262	227	3
4	5	Utilities	Resident Days	75	23,319	0	44,262	802	4
5	6	Maintenance	Resident Days	75	205,135	187,746	44,262	7,057	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	44,262	0	6
7	9	Medical Director	Resident Days	75	0	0	44,262	0	7
8	10	Nursing and Medical Records	Resident Days	75	320,054	736,064	44,262	11,010	8
9	10A	Therapy	Resident Days	75	0	0	44,262	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	44,262	0	10
11	17	Administrative	Resident Days	75	1,899,564	7,673,667	44,262	65,345	11
12	19	Professional Services	Resident Days	75	1,122,027	0	44,262	38,597	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	174,864	0	44,262	6,015	13
14	21	Clerical and General Office	Resident Days	75	2,117,879	2,195,755	44,262	72,855	14
15	22	Employee Benefits and Payroll Ta	Resident Days	75	581,392	0	44,262	20,000	15
16	23	Inservice Training & Education	Resident Days	75	3,515	0	44,262	121	16
17	24	Travel and Seminar	Resident Days	75	1,093	0	44,262	38	17
18	25	Other Admin. Staff Transport.	Resident Days	75	244,707	0	44,262	8,418	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	37,296	0	44,262	1,283	19
20	30	Depreciation	Resident Days	75	345,756	0	44,262	11,894	20
21	31	Amortization	Resident Days	75	0	0	44,262	0	21
22	32	Interest	Resident Days	75	16,848	0	44,262	579	22
23	33	Real Estate Taxes	Resident Days	75	13,448	0	44,262	463	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	124,022	0	44,262	4,266	24
25	TOTALS				\$ 7,579,080	\$ 11,195,006		\$ 260,719	25

Facility Name & ID Number Royal Oaks Care Center# 0056481

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	92,563	5	\$	\$	26,358	\$	1
2	2	Food	Resident Days	92,563	5			26,358		2
3	3	Housekeeping	Resident Days	92,563	5			26,358		3
4	4	Laundry	Resident Days	92,563	5			26,358		4
5	5	Utilities	Resident Days	92,563	5			26,358		5
6	6	Maintenance	Resident Days	92,563	5			26,358		6
7	7	Mgmt. Allocation of Benefits	Resident Days	92,563	5			26,358		7
8	10	Nursing and Medical Records	Resident Days	92,563	5	5,954		26,358	1,695	8
9	15	Mgmt. Allocation of Benefits	Resident Days	92,563	5			26,358		9
10	17	Administrative	Resident Days	92,563	5			26,358		10
11	19	Professional Services	Resident Days	92,563	5	1,829,164		26,358	520,868	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	92,563	5			26,358		12
13	21	Clerical and General Office	Resident Days	92,563	5			26,358		13
14	22	Employee Benefits & Payroll	Resident Days	92,563	5	1,233		26,358	351	14
15	23	Inservice Training & Education	Resident Days	92,563	5			26,358		15
16	24	Travel and Seminar	Resident Days	92,563	5			26,358		16
17	25	Other Admin. Staff Transport.	Resident Days	92,563	5			26,358		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	92,563	5			26,358		18
19	30	Depreciation	Resident Days	92,563	5	2,726		26,358	776	19
20	31	Amortization	Resident Days	92,563	5			26,358		20
21	32	Interest	Resident Days	92,563	5	42,259		26,358	12,034	21
22	33	Real Estate Taxes	Resident Days	92,563	5			26,358		22
23	34	Rent-Facility and Grounds	Resident Days	92,563	5			26,358		23
24	35	Rent-Equipment & Vehicles	Resident Days	92,563	5	670,184		26,358	190,840	24
25	TOTALS					\$ 2,551,520	\$		\$ 726,564	25

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		2		3	4	5	6		7	8	9	10	
	Name of Lender	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					
	A. Directly Facility Related												
	Long-Term												
1	Huntington Bank		X	Mortgage	Varies	2/1/17	\$ 3,337,200	\$ Paid	1/31/37	Varies	\$ 22,145	1	
2	South Bus and Mobility		X	Vehicle	\$590.88	4/2/18	13,886	Paid	4/1/21	0.0700	390	2	
3	Sector		X	Mortgage	Varies	4/1/20	9,401,541	9,401,541	3/1/23	Varies	710,601	3	
4	Dodge		X	Vehicle	Varies	6/29/20	39,027	37,125	6/25/25		390	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$590.88		\$ 12,791,654	\$ 9,438,666			\$ 733,526	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(4,953)	10	
11								Home Office Allocation-PHCM			579	11	
12								Home Office Allocation-PHC II			12,034	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 7,660	14	
15	TOTALS (line 9+line14)						\$ 12,791,654	\$ 9,438,666			\$ 741,186	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.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.				
1. Real Estate Tax accrual used on 2019 report.	\$	79,128		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.)	\$	76,578		2	
3. Under or (over) accrual (line 2 minus line 1).	\$	(2,550)		3	
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	78,876		4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	463		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	76,789		7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	73,173	8		
	2016	73,041	9		
	2017	76,674	10		
	2018	76,825	11		
	2019	76,578	12		
Accrual based on prior year tax bill.					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019 \$		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.

FACILITY NAME Royal Oaks Care Center COUNTY Henry
FACILITY IDPH LICENSE NUMBER 0046243
CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER
TELEPHONE (309)689-5850 FAX #: (309)691-8622

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,875

B. General Construction Type: Exterior BrickFrame 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: 470,764

2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 176,536

4. Dates Incurred: 2020

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	Facility	362,419	2003	\$ 200,000	1
2					2
3	TOTALS	362,419		\$ 200,000	3

Facility Name & ID Number Royal Oaks Care Center

0056481

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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	\$ 49,400	\$ 734,931	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Water Softener			2003	14,625		7			14,625	9
10	Service Road			2004	6,940		15			6,940	10
11	Sidewalk			2004	2,600		15			2,600	11
12	Air Conditioning			2004	5,101		25	204	204	3,291	12
13	Fire Alarm			2004	5,810		25	232	232	3,743	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	428	428	6,378	16
17	Driveway			2007	7,625		15	508	508	6,868	17
18	Sidewalk			2007	7,200		15	480	480	6,480	18
19	Smoke Detectors			2007	4,400		10			4,400	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			5,544	22
23	Sprinkler System			2012	159,900		25	6,396	6,396	54,366	23
24	Carpeting-Lobby and Main Area			2013	31,230		15	2,082	2,082	15,615	24
25	Roof Replacement			2013	155,855		25	6,234	6,234	46,755	25
26	Flooring-Dining Hall			2013	12,409		15	856	856	3,838	26
27	Furnace Replacement			2014	124,562		25	4,983	4,983	32,390	27
28	Vinyl Tile & Carpet Installation in Hallways, Common Areas			2014	28,272		15	1,885	1,885	12,632	28
29	Nurses Station			2014	37,675		15	2,512	2,512	21,041	29
30	Water Heater			2014	4,734		7	676	676	4,394	30
31	Heat Pump			2014	7,566		25	303	303	1,970	31
32	Water Heater			2015	4,015		7	574	574	3,157	32
33	Air Conditioner			2016	2,518		7	360	360	1,620	33
34	Exterior Landscaping			2016	11,437		7	1,634	1,634	7,353	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

0056481

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Water Heater	2018	\$ 2,828	\$	7	\$ 404	\$ 404	\$ 1,010	37
38 Water Heater and Hot Water Storage Tank Replacement	2019	17,482		7	2,498	2,498	3,747	38
39 Copper Pipe Repair	2020	4,069		7	291	291	291	39
40 Water Pipe Repair	2020	6,315		7	451	451	451	40
41 Plumbing Repair	2020	10,528		7	752	752	752	41
42 Parking Lot Resurfacing	2020	79,075		15	2,636	2,636	2,636	42
43 Sidewalk Addition	2020	6,170		15	206	206	206	43
44 Water Pipe Repair	2020	5,361		7	383	383	383	44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57 Land Improvements Booked			480			(480)		57
58 Building Booked			38,229			(38,229)		58
59 Building Improvement Booked			48,233			(48,233)		59
60								60
61 2020-Home Office Allocation-Building Improvements		22,312			535	535		61
62 2020-Home Office Allocation-Land Improvements		2,238			142	142		62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,777,089	\$ 86,942		\$ 88,045	\$ 1,103	\$ 1,058,126	70

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

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	\$ 113,188	\$ 9,087	\$ 7,705	\$ (1,382)	5-10 yrs.	\$ 79,845	71
72	Current Year Purchases	7,530	323	538	215	7 yrs.	538	72
73	Fully Depreciated Assets	618,306					618,306	73
74	Home Office Allocation			11,993	11,993			74
75	TOTALS	\$ 739,024	\$ 9,410	\$ 20,236	\$ 10,826		\$ 698,689	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
77	Facility Use	2015 Ford Van	2018	13,886	3,009	2,777	(232)	5 yrs.	6,943
78	Facility Use	2019 Dodge Caravan	2020	39,027	3,903	3,903		5 yrs.	3,903
79									
80	TOTALS			\$ 83,946	\$ 6,912	\$ 6,680	\$ (232)		\$ 41,879

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	3,800,059
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	103,264
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	114,961
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	11,697
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	1,798,694

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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO
16. Rental Amount for movable equipment: \$ 223,776 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	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending	Annual Rent
12. /2021	\$
13. /2022	\$
14. /2023	\$

* 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
0056481
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	21,003
Dishwasher		1,594
Copier		6,073
Home Office Allocation		<u>195,106</u>
		<u><u>223,776</u></u>

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	\$			

- (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.

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	

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

		1	2	3	4	5	6	7	8	
	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	\$	4,312	\$ 64,686	\$	4,312	\$ 64,686	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,255	18,829		1,255	18,829	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,509	97,635		6,509	97,635	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				49,983		49,983	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	12,076	\$ 181,150	\$ 49,983	12,076	\$ 231,133	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (2,707)	\$ (2,707)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,559)	2,513,588	2,513,588	3
4	Supply Inventory (priced at Cost)	25,167	25,167	4
5	Short-Term Investments			5
6	Prepaid Insurance	49,220	49,220	6
7	Other Prepaid Expenses	2,708,837	2,708,837	7
8	Accounts Receivable (owners or related parties)		32,610	8
9	Other(specify): Employee Education Loans	2,119	2,119	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,296,224	\$ 5,328,834	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		200,000	13
14	Buildings, at Historical Cost		1,948,908	14
15	Leasehold Improvements, at Historical Cost	107,449	828,181	15
16	Equipment, at Historical Cost	91,475	822,970	16
17	Accumulated Depreciation (book methods)	(49,799)	(1,798,694)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		294,228	19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds	33,201	753,695	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	683,501	683,501	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 865,827	\$ 3,732,789	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,162,051	\$ 9,061,623	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,148,503	\$ 1,148,503	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	158,291	158,291	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	198,787	198,787	31
32	Accrued Real Estate Taxes(Sch.IX-B)	78,876	78,876	32
33	Accrued Interest Payable		112,747	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	2,712	2,712	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,587,169	\$ 1,699,916	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	37,125	37,125	39
40	Mortgage Payable		9,401,541	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	2,325,578	1,743,278	43
44	Loan Payable-MCAD Adv. & SBA PPP	657,000	657,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,019,703	\$ 11,838,944	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,606,872	\$ 13,538,860	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,555,179	\$ (4,477,237)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,162,051	\$ 9,061,623	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,371,062)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	1,354,863	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (16,199)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,571,378	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)	\$ 1,571,378	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,555,179	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Royal Oaks Care Center

0056481

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,695,067	1
2	Discounts and Allowances for all Levels	(1,437,957)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,257,110	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	331,925	6
7	Oxygen	4,421	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 336,346	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	1,389	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	57,203	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,556	20
21	Other Medical Services	12,993	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 79,141	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,953	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,953	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	(273)	28
28a	<u>Miscellaneous & COVID Stimulus Revenue</u>	1,045,414	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,045,141	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,722,691	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,226,826	31
32	Health Care	3,072,136	32
33	General Administration	1,074,538	33
	B. Capital Expense		
34	Ownership	1,309,163	34
	C. Ancillary Expense		
35	Special Cost Centers	103,910	35
36	Provider Participation Fee	364,740	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,151,313	40
41	Income before Income Taxes (line 30 minus line 40)**	1,571,378	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,571,378	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 6,174,081	44
45	Private Pay - Net Inpatient Revenue	428,960	45
46	Medicare - Net Inpatient Revenue	645,033	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	9,036	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,257,110	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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	2,057	2,057	\$ 80,606	\$ 39.19	1
2	Assistant Director of Nursing	1,184	1,269	31,240	24.62	2
3	Registered Nurses	8,282	8,510	260,195	30.58	3
4	Licensed Practical Nurses	29,159	29,921	750,251	25.07	4
5	CNAs & Orderlies	87,354	89,731	1,204,913	13.43	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,936	2,047	26,510	12.95	9
10	Activity Assistants	3,996	4,076	44,212	10.85	10
11	Social Service Workers	6,072	6,152	101,912	16.57	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	32,087	15.43	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,519	19,728	200,757	10.18	15
16	Dishwashers					16
17	Maintenance Workers	4,020	4,086	68,264	16.71	17
18	Housekeepers	19,438	19,977	213,689	10.70	18
19	Laundry	7,519	7,810	87,557	11.21	19
20	Administrator	1,851	2,017	65,004	32.23	20
21	Assistant Administrator	1,040	1,040	22,750	21.88	21
22	Other Administrative					22
23	Office Manager	2,080	2,080	49,840	23.96	23
24	Clerical	2,040	2,080	27,376	13.16	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	962	962	24,129	25.08	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	4,979	5,207	151,421	29.08	33
34	TOTAL (lines 1 - 33)	205,568	210,830	\$ 3,442,713 *	\$ 16.33	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	13,881	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	80	4,862	L10, C3	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)	80	\$ 30,743		49

C. CONTRACT NURSES

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

Royal Oaks Care Center
0056481
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		3,003	3,127	108,083
Transportation		1,976	2,080	43,338
	TOTAL	4,979	5,207	151,421

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Karessa Crone	Administrator	0	\$ 65,004
Kylie Likes	Asst. Administrator	0	22,750
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,754
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7		\$	384,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 384,500
C. Professional Services			
Vendor/Payee	Type		Amount
Ability Network	Computer Services	\$	8,682
Comcast Cable	Computer Services		1,421
Peoples National Bank	Legal Fees-7/14/20		30
Illinois Secretary of State	Legal Filing Fees-6/22/20		155
Henry County Recorder	Legal Filing Fees-5/13/20		68
Sector Bank	Title Lien Search-July 2020		819
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 11,175
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	48,429
Unemployment Compensation Insurance			42,986
FICA Taxes			253,915
Employee Health Insurance			8,081
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			1,130
Home Office Allocation			20,351
Employee Retirement			758
Administrator Benefits			12,996
TOTAL (agree to Schedule V, line 22, col.8)			\$ 388,646
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	1,990
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 14)			
Patient Background Checks	59		1,773
Miscellaneous Licenses & Permits			956
Miscellaneous Dues & Subscriptions			600
Home Office Allocation			6,015
Less: Public Relations Expense			(600)
Non-allowable advertising	(		)
Yellow page advertising	(		)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 10,734
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			
Home Office Allocation			38
Entertainment Expense	(		)
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	38

*** Attach copy of IMRF notifications**

****See instructions.**

Royal Oaks Care Center
0056481
Period Beginning1/1/2020
Period End12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,175
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	680
Duane Morris	Legal	950
Lexis Nexis	Legal	18
Livingston, Barger, Brant, Schroeder	Legal	36
Miller, Hall, Triggs	Legal	117
Miscellaneous	Legal	44
SB2	Legal	351
SmithAmundsen LLC	Legal	2,171
Sorling Northrup	Legal	619
Applegate & Thorne	Legal	19,778
Baker Tilly Virchow Krause LLP	Legal	1,863
Boyle Brasher LLC	Legal	2,051
Bureau Veritas Technical Assessment	Legal	1,137
Chapman and Keller	Legal	80,297
CliftonLarsonAllen	Legal	4,784
Duane Morris	Legal	162,722
Elias, Meginnes, Seghetti	Legal	166
Illinois Secretary of State	Legal	228
Lashly & Baer	Legal	2,252
Livingston, Barger, Brandt, Schroeder	Legal	8,214
Moore, Susler, McNutt, Wrigley	Legal	2,729
Saul Ewing Artstein & Lehr	Legal	614
Sector	Legal	17,520
Sedgwick Claims Management	Legal	53,638
SmithAmundsen	Legal	9,291
Sorling Northrup	Legal	2,393
SPI Corporate Solutions	Legal	26,225
Stanley, Lande and Hunter	Legal	907
CliftonLarsonAllen	Accounting	5,138
Ginoli & Co.	Accounting	2,826
Ability Network	Computer Services	6,927
Allscripts	Computer Services	1,093
AOD Matrix Care	Computer Services	12,165
AT&T	Computer Services	13
ATS	Computer Services	663
CCH	Computer Services	39
Charter Communications	Computer Services	61
Citrix Systems	Computer Services	207
Comcast	Computer Services	71
ITSavvy	Computer Services	320
Kemper Technology	Computer Services	1,581
Miscellaneous	Computer Services	307
Pearl Technology	Computer Services	286
Stratus Networks	Computer Services	1,256
TR Professional	Computer Services	27
David Budde	Other Prof Fees	28
DJ Howard and Associates	Other Prof Fees	53
Getzler Henrich & Associates	Other Prof Fees	214
LRI Consulting Services	Other Prof Fees	208
McQuellon Consulting	Other Prof Fees	132
Miscellaneous	Other Prof Fees	316
Optimizer	Other Prof Fees	113
Registered Agent Solutions	Other Prof Fees	63
RSM McGladrey	Other Prof Fees	687
SB2	Other Prof Fees	878
Sedgwick CMS	Other Prof Fees	1,183
Tarver Program Consultants	Other Prof Fees	164
D.J. Howard & Associates	Other Prof Fees	2,136
Creative Health Capital	Other Prof Fees	21,200
Getzler Henrich & Associates	Other Prof Fees	20,001
Health Dimensions	Other Prof Fees	2,847
Mohr & Kerr Engineering and Land Surveying	Other Prof Fees	53,499
SB2	Other Prof Fees	1,708
Scott Commuication Solutions	Other Prof Fees	4,271
Sedgwick Claims Management	Other Prof Fees	14,989
Total (agree to Schedule V, line 19, column 8)		570,640

Royal Oaks Care Center
0056481
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	4,930
Auto Repairs		2,735
Mileage-Travel		41
Home Office Allocation		<u>8,418</u>
		<u>16,124</u>

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?
If YES, give association name and amount.

No

(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?
What was the average life used for new equipment added during this period?

Yes

7 yrs.

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

45,749

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?
If YES, give effective date of lease.

No

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.

\$

364,740

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.

\$

1,389

(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.

\$

273

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

Yes

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.

\$

(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 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.

HFS 3745 (N-4-99)

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