FOR BHF USE

LL1

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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0047514

Facility Name: North Aurora Care Center

Address: 310 Banbury Road (Number) North Aurora (City) 60542 (Zip Code)

County: Kane

Telephone Number: (630) 892-7627 **Fax #** (630) 692-7925

HFS ID Number:

Date of Initial License for Current Owners: 10/01/05

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mike Kocher **Telephone Number:** (309)689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2015 to 12/31/2015 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.

Officer or Administrator of Provider
(Signed)
(Date)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid Preparer
(Signed)
(Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	129	Intermediate (ICF)	129	47,085	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	129	TOTALS	129	47,085	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	39,446	1,375		40,821	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,446	1,375		40,821	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.70%

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

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

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

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

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

I. On what date did you start providing long term care at this location?
Date started 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	191,622	20,528	912	213,062		213,062	7,911	220,973			1
2	Food Purchase		244,715		244,715		244,715	(1,613)	243,102			2
3	Housekeeping	152,375	47,214		199,589		199,589	62	199,651			3
4	Laundry	54,494	10,257		64,751		64,751		64,751			4
5	Heat and Other Utilities			111,855	111,855		111,855	455	112,310			5
6	Maintenance	71,610	16,365	28,486	116,461		116,461	3,137	119,598			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	470,101	339,079	141,253	950,433		950,433	9,952	960,385			8
	B. Health Care and Programs											
9	Medical Director			10,800	10,800		10,800		10,800			9
10	Nursing and Medical Records	1,678,489	88,620	8,299	1,775,408		1,775,408	(3,466)	1,771,942			10
10a	Therapy											10a
11	Activities	108,348	645	68	109,061		109,061	(6,123)	102,938			11
12	Social Services	127,332			127,332		127,332		127,332			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	1,914,169	89,265	19,167	2,022,601		2,022,601	(9,589)	2,013,012			16
	C. General Administration											
17	Administrative			357,200	357,200		357,200	(265,060)	92,140			17
18	Directors Fees											18
19	Professional Services			7,040	7,040		7,040	87,443	94,483			19
20	Dues, Fees, Subscriptions & Promotions			7,245	7,245		7,245	6,356	13,601			20
21	Clerical & General Office Expenses	56,358	8,218	14,392	78,968		78,968	88,617	167,585			21
22	Employee Benefits & Payroll Taxes			338,827	338,827		338,827	48,170	386,997			22
23	Inservice Training & Education							610	610			23
24	Travel and Seminar							139	139			24
25	Other Admin. Staff Transportation			7,985	7,985		7,985	6,225	14,210			25
26	Insurance-Prop.Liab.Malpractice			34,054	34,054		34,054	11,993	46,047			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	56,358	8,218	766,743	831,319		831,319	(15,507)	815,812			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,440,628	436,562	927,163	3,804,353		3,804,353	(15,144)	3,789,209			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 North Aurora Care Center #0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			1,521	1,521		1,521	107,031	108,552			30
31	Amortization of Pre-Op. & Org.							9,236	9,236			31
32	Interest							117,022	117,022			32
33	Real Estate Taxes							90,118	90,118			33
34	Rent-Facility & Grounds			410,624	410,624		410,624	(410,624)				34
35	Rent-Equipment & Vehicles			49,340	49,340		49,340	1,201	50,541			35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			461,485	461,485		461,485	(86,016)	375,469			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			318,340	318,340		318,340		318,340			42
43	Other (specify):* Home Office Ben. Allocati			172,095	172,095		172,095	(172,095)				43
44	TOTAL Special Cost Centers			490,435	490,435		490,435	(172,095)	318,340			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,440,628	436,562	1,879,083	4,756,273		4,756,273	(273,255)	4,483,018			45

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,626)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,141)	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	1,792	30		9
10	Interest and Other Investment Income	(612)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(109)	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	(165,965)	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				24
25	Fund Raising, Advertising and Promotional	(900)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(9,886)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (182,447)		$	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)	(90,808)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (90,808)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (273,255)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

North Aurora Care Center

ID# **0047514**

Report Period Beginning: **1/1/2015**

Ending: **12/31/2015**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Transportation Revenue	$ (6,123)	11	1
2	Offset Miscellaneous Income - Office Supplies	(75)	21	2
3	Disallowed Special Events	20	43	3
4	Offset Miscellaneous Income - Nursing Supplies	(3,708)	10	4
5				5
6				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
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(9,886)		49

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 0	$	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	0		3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	0		4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	0		5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	398	398	12
13	V								13
14	Total			$			$ 398	$ * 398	14

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 107	$ 107	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	0		16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	0		17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	0		18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	0		19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	0		20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	0		21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	1,547	1,547	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	0		24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	0		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			$			$ 1,654	$ * 1,654	39

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Operations, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Operations, LLC	100.00%	65,890	65,890	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	5,998	5,998	26
27	V	21	Clerical and General Office		Petersen Health Operations, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	(11,144)	(11,144)	28
29	V	23	Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Operations, LLC	100.00%	4,114	4,114	33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	154	154	35
36	V	33	Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total			$			$ 65,012	$ * 65,012	39

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 7,911	$ 7,911	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	13	13	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	62	62	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	455	455	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,137	3,137	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	242	242	22
23	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	17	Administrative	357,200	Petersen Health Care Management, Inc.	100.00%	92,140	(265,060)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	13,993	13,993	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	251	251	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	88,692	88,692	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	59,314	59,314	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	610	610	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	139	139	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	6,225	6,225	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	956	956	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	14,208	14,208	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	458	458	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	1,037	1,037	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,201	1,201	38
39	Total			$ 357,200			$ 291,044	$ * (66,156)	39

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Services	$	North Aurora Land		$ 7,162	$ 7,162	15
16	V	26	Insurance-Property		North Aurora Land		7,789	7,789	16
17	V	26	Insurance- MIP		North Aurora Land		3,248	3,248	17
18	V	30	Depreciation		North Aurora Land		85,370	85,370	18
19	V	31	Amortization		North Aurora Land		9,236	9,236	19
20	V	32	Interest		North Aurora Land		117,022	117,022	20
21	V	33	Real Estate Taxes		North Aurora Land		89,081	89,081	21
22	V	34	Rent-Income and Grounds	410,624	North Aurora Land			(410,624)	22
23	V								23
24	V								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			$ 410,624			$ 318,908	$ * (91,716)	39

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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, L	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 Syster	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 Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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								4
5								5
6								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 North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
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 North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 2/31/2015

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care, Inc.
Street Address: 830 W. Trailcreek Drive
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 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	1,553,881	75	$ 231,472	$ 220,289	40,821	$ 0	1
2	2	Food	Resident Days	1,553,881	75	5,535	0	40,821	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	1,186	0	40,821	0	3
4	5	Utilities	Resident Days	1,553,881	75	15,620	0	40,821	0	4
5	6	Maintenance	Resident Days	1,553,881	75	87,840	72,289	40,821	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	40,821	0	6
7	9	Medical Director	Resident Days	1,553,881	75	1,878	0	40,821	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	73	0	40,821	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	40,821	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	40,821	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	40,821	0	11
12	19	Professional Services	Resident Days	1,553,881	75	199,629	0	40,821	398	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	11,118	0	40,821	107	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	2,605,683	2,406,945	40,821	0	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	118,476	0	40,821	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	1,318	0	40,821	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	813	0	40,821	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	210,725	0	40,821	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	37,142	0	40,821	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	40,821	0	20
21	30	Depreciation	Resident Days	1,553,881	75	212,796	0	40,821	1,547	21
22	32	Interest	Resident Days	1,553,881	75	135,329	0	40,821	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	10,455	0	40,821	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	53,539	0	40,821	0	24
25	TOTALS					$ 3,940,627	$ 2,699,523		$ 2,052	25

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 2/31/2015

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 [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Operations, 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 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	210,530	9	$	$	40,821	$	1
2	2	Food	Resident Days	210,530	9			40,821		2
3	3	Housekeeping	Resident Days	210,530	9			40,821		3
4	4	Laundry	Resident Days	210,530	9			40,821		4
5	5	Utilities	Resident Days	210,530	9			40,821		5
6	6	Maintenance	Resident Days	210,530	9			40,821		6
7	7	Mgmt. Allocation of Benefits	Resident Days	210,530	9			40,821		7
8	10	Nursing and Medical Records	Resident Days	210,530	9			40,821		8
9	15	Mgmt. Allocation of Benefits	Resident Days	210,530	9			40,821		9
10	17	Administrative	Resident Days	210,530	9			40,821		10
11	19	Professional Services	Resident Days	210,530	9	1,618,180		40,821	65,890	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	210,530	9	3,515		40,821	5,998	12
13	21	Clerical and General Office	Resident Days	210,530	9			40,821		13
14	22	Employee Benefits & Payroll	Resident Days	210,530	9	37,246		40,821	(11,144)	14
15	23	Inservice Training & Education	Resident Days	210,530	9			40,821		15
16	24	Travel and Seminar	Resident Days	210,530	9			40,821		16
17	25	Other Admin. Staff Transport.	Resident Days	210,530	9			40,821		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	210,530	9			40,821		18
19	30	Depreciation	Resident Days	210,530	9	44,533		40,821	4,114	19
20	31	Amortization	Resident Days	210,530	9			40,821		20
21	32	Interest	Resident Days	210,530	9	186,049		40,821	154	21
22	33	Real Estate Taxes	Resident Days	210,530	9			40,821		22
23	34	Rent-Facility and Grounds	Resident Days	210,530	9			40,821		23
24	35	Rent-Equipment & Vehicles	Resident Days	210,530	9			40,821		24
25	TOTALS					$ 1,889,523	$		$ 65,012	25

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 2/31/2015

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 [X] 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 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	1,553,881	75	$ 299,960	$ 259,597	40,821	$ 7,911	1
2	2	Food	Resident Days	1,553,881	75	674		40,821	13	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,071	488	40,821	62	3
4	5	Utilities	Resident Days	1,553,881	75	4,350		40,821	455	4
5	6	Maintenance	Resident Days	1,553,881	75	111,954	82,720	40,821	3,137	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			40,821		6
7	9	Medical Director	Resident Days	1,553,881	75			40,821		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	1,461		40,821	242	8
9	10A	Therapy	Resident Days	1,553,881	75			40,821		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			40,821		10
11	17	Administrative	Resident Days	1,553,881	75	4,576,674	4,027,473	40,821	92,140	11
12	19	Professional Services	Resident Days	1,553,881	75	450,945		40,821	13,993	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	3,615		40,821	251	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,292,042	2,769,270	40,821	88,692	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	1,135,675		40,821	59,314	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	1,076		40,821	610	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	1,251		40,821	139	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	111,953		40,821	6,225	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	9,414		40,821	956	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			40,821		20
21	30	Depreciation	Resident Days	1,553,881	75	14,424		40,821	14,208	21
22	32	Interest	Resident Days	1,553,881	75	19,136		40,821	458	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	8,075		40,821	1,037	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	25,089		40,821	1,201	24
25	TOTALS					$ 10,069,839	$ 7,139,549		$ 291,044	25

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Merit		X	Mortgage	Varies	9/15/14	$ 3,142,700	$ 3,034,280	12/31/34	Varies	$ 118,476	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,142,700	$ 3,034,280			$ 118,476	9
	B. Non-Facility Related*											
10								Interest Income Offset			(2,066)	10
11								Home Office Allocation-PHO			154	11
12								Home Office Allocation-PHCM			458	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,454)	14
15	TOTALS (line 9+line14)						$ 3,142,700	$ 3,034,280			$ 117,022	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 3,248 Line # 26

* 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.)

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	84,108	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.)	$	85,313	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,205	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)	$	87,876	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**		1,037	
TOTAL REFUND $ **For** **Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	90,118	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	53,704	8
	2011	63,822	9
	2012	73,021	10
	2013	81,656	11
	2014	85,313	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Aurora Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047514

CONTACT PERSON REGARDING THIS REPORT MARK PETERSEN

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2014 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 2014.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-34-329-052	Long-Term Care Facility	$ 85,165.74	$ 85,165.74
2.	12-34-331-005	Lot	$ 147.44	$ 147.44
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 85,313.18	$ 85,313.18

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,812 B. General Construction Type: Exterior Masonry Frame Brick 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: 203,196
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 9,236
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.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	27,812	2005	$ 72,000	1
2					2
3	TOTALS	27,812		$ 72,000	3

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	129		2005	1972	$ 1,313,500	$	25	$ 52,540	$ 52,540	$ 555,070	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	15,000		15	1,000	1,000	10,500	9
10	Sidewalks			2006	23,280		15	1,552	1,552	14,744	10
11	Water Line Replacement			2006	3,775		25	151	151	1,435	11
12	Water Pump Replacement			2006	3,200		15	213	213	2,024	12
13	Fence			2007	6,150		15	410	410	3,485	13
14	Coil-Water Heater			2007	4,900		15	327	327	2,779	14
15	Compressor			2007	3,295		15	220	220	1,977	15
16	Employee Breakroom (Cabinets, Counter, Sink, Mouldings)			2007	2,976		15	198	198	1,634	16
17	Sprinkler repair			2008	3,782		20	190	190	1,425	17
18	Backflow preventer			2008	6,400		25	256	256	1,920	18
19	Renovations for bathrooms and tub rooms			2008	23,000		39	590	590	4,425	19
20	Fence			2009	8,270		15	552	552	3,588	20
21	Pipe Valve Repair			2009	4,406		7	630	630	4,095	21
22	Video Camera System			2009	7,357		5			7,357	22
23	Sprinkler System Installation			2009	25,768		20	1,288	1,288	8,372	23
24	Security Lock System			2009	12,131		5			12,131	24
25	Sprinkler Installation in Lower Level			2009	12,272		20	614	614	3,991	25
26	Fence			2010	3,663		15	244	244	1,342	26
27	Sprinkler System Repair			2010	8,354		15	556	556	3,058	27
28	A/C Unit			2010	2,625		15	176	176	968	28
29	Parking Lot			2010	183,686		25	7,415	7,415	47,289	29
30	Sprinkler System Repair			2011	5,987		7	856	856	3,852	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Water Main Repair	2012	$ 3,300	$	7	$ 472	$ 472	$ 1,652	37
38	Boiler	2012	7,666		15	512	512	1,792	38
39	Fire Alarm Installation	2012	5,363		7	766	766	2,681	39
40	Water Main Repair	2012	3,933		7	562	562	1,405	40
41	Gutter and Soffit Replacement	2013	34,150		25	1,366	1,366	3,415	41
42	Air Conditioner	2014	2,851		15	190	190	285	42
43	Roof Replacement	2014	134,525		25	5,381	5,381	8,072	43
44	Fire Sprinkler Line Repair	2015	5,242		7	375	375	375	44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63	Land Improvements Booked			11,173			(11,173)		63
64	Building Booked			51,981			(51,981)		64
65	Building Improvement Booked			16,222			(16,222)		65
66									66
67	2015-Home Office Allocation-Building Improvements		17,861			428	428		67
68	2015-Home Office Allocation-Land Improvements		1,667			107	107		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,900,335	$ 79,376		$ 80,137	$ 761	$ 717,138	70

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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	$ 74,620	$ 5,994	$ 7,714	$ 1,720	5-10 yrs.	$ 43,370	71
72	Current Year Purchases	6,282	468	314	(154)	10 yrs.	314	72
73	Fully Depreciated Assets	286,556					286,556	73
74	Home Office Allocation			19,334	19,334			74
75	TOTALS	$ 367,458	$ 6,462	$ 27,362	$ 20,900		$ 330,240	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	2006 Ford E-350	2012	$ 5,266	$ 1,053	$ 1,053	$	5 yrs.	$ 3,688	76
77										77
78										78
79										79
80	TOTALS			$ 5,266	$ 1,053	$ 1,053	$		$ 3,688	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,345,059	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,891	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 108,552	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,661	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,051,066	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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: *

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 43,678 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	Facility	2006 Ford E250	$ 571.88	$ 6,863	17
18					18
19					19
20					20
21	TOTAL		$ 571.88	$ 6,863	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.

North Aurora Care Center
0047514
Period Beginning 1/1/2015
Period End 12/31/2015

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	31,000
Dishwasher		1,050
Copier		10,427
Home Office Allocation		1,201
		43,678

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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)	$			

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	N/A	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	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.

STATE OF ILLINOIS

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (104,164)	$ (104,164)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 260,997)	1,724,601	1,724,601	3
4	Supply Inventory (priced at Cost)	16,424	16,424	4
5	Short-Term Investments			5
6	Prepaid Insurance	41,390	58,279	6
7	Other Prepaid Expenses		32,075	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposit/Emp Loan	3,355	3,355	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,681,606	$ 1,730,570	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		72,000	13
14	Buildings, at Historical Cost		1,331,361	14
15	Leasehold Improvements, at Historical Cost		568,974	15
16	Equipment, at Historical Cost	11,548	372,724	16
17	Accumulated Depreciation (book methods)	(4,505)	(1,051,066)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	(1)	203,195	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(11,545)	20
21	Restricted Funds		597,633	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,042	$ 2,083,276	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,688,648	$ 3,813,846	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 573,590	$ 586,244	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,463	125,463	30
31	Accrued Taxes Payable (excluding real estate taxes)	107,943	107,943	31
32	Accrued Real Estate Taxes(Sch.IX-B)		87,876	32
33	Accrued Interest Payable		9,735	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	340,014	340,014	36
37	Accrued Management Fees	90,675	90,675	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,237,685	$ 1,347,950	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,034,280	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	1,213,265	80,539	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,213,265	$ 3,114,819	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,450,950	$ 4,462,769	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (762,302)	$ (648,923)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,688,648	$ 3,813,846	48

*(See instructions.)

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,060,798)	1
2	Restatements (describe):		2
3	**Prior Period Adjustments Made After Cost Report Was Filed**	39,413	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,021,385)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	259,083	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)**	$ 259,083	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)**	$ (762,302)	24 *

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,003,212	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,003,212	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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	1,626	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,626	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	612	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 612	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	6,123	28
28a	Miscellaneous Revenue	3,783	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,906	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,015,356	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	950,433	31
32	Health Care	2,022,601	32
33	General Administration	831,319	33
	B. Capital Expense		
34	Ownership	461,485	34
	C. Ancillary Expense		
35	Special Cost Centers	172,095	35
36	Provider Participation Fee	318,340	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,756,273	40
41	**Income before Income Taxes (line 30 minus line 40)****	259,083	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 259,083	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,805,217	44
45	Private Pay - Net Inpatient Revenue	197,995	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,003,212	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.**

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	7,020	2,080	$ 76,531	$ 36.79	1
2	Assistant Director of Nursing	2,128	2,128	73,285	34.44	2
3	Registered Nurses	6,641	6,919	229,193	33.13	3
4	Licensed Practical Nurses	17,349	18,153	520,514	28.67	4
5	CNAs & Orderlies	45,339	47,813	663,723	13.88	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	29,321	14.10	9
10	Activity Assistants	3,336	3,336	33,509	10.04	10
11	Social Service Workers	6,597	6,637	127,332	19.19	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,558	14.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,836	14,628	162,064	11.08	15
16	Dishwashers					16
17	Maintenance Workers	3,986	4,074	71,610	17.58	17
18	Housekeepers	13,944	14,575	152,375	10.45	18
19	Laundry	5,601	5,857	54,494	9.30	19
20	Administrator	2,080	2,080	92,140	44.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,833	4,129	56,358	13.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,825	3,825	115,243	30.13	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Transportation	1,885	2,082	45,518	21.86	33
34	TOTAL (lines 1 - 33)	141,560	142,476	$ 2,532,768 *	$ 17.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	16	$ 912	L1, C3	35
36	Medical Director	Monthly	10,800	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,158	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	116	L10A, 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)	18	$ 19,986		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Bogard	Administrator	0	$ 92,140
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 92,140

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 357,200
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 357,200

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 4,245
AT&T	Internet Services	1,055
Comcast	Internet Services	414
Honkamp Kruger	Accounting Services	1,326
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 7,040

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 115,955
Unemployment Compensation Insurance	58,128
FICA Taxes	180,626
Employee Health Insurance	(17,409)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,006
Employee Retirement	521
Home Office Allocation	48,170
TOTAL (agree to Schedule V, line 22, col.8)	$ 386,997

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 239)	2,453
Miscellaneous Licenses & Permits	752
Miscellaneous Dues & Subscriptions	60
Home Office Allocation	6,356
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,601

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	139
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 139

**See instructions.

North Aurora Care Center
0047514
Period Beginning **1/1/2015**
Period End **12/31/2015**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		7,040
Home Office Allocation		
Denton's US LLP	Legal	198
Applegate and Thorne	Legal	31
Miller Hall and Triggs	Legal	30
Healthcare Resources International	Legal	163
Lexis Nexis	Legal	12
GoffWilson	Legal	1362
Illinois Secretary of State	Legal	48
Edgerton and Edgerton	Legal	213
Black, Hedin, Ballard, McDonald	Legal	182
Cole Schotz LLC	Legal	481
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	2,124
Ginoli & Co.	Accountants	8,365
Miscellaneous	Computer Services	96
CCH	Computer Services	24
PTC Select	Computer Services	32
Advanced Answers on Demand	Computer Services	4356
Stratus Networks	Computer Services	792
Kemper Technology	Computer Services	1165
AT&T	Computer Services	10
Ability Network	Computer Services	1122
CIAN	Computer Services	789
Comcast	Computer Services	30
Emdeon	Computer Services	65
Charter Communications	Computer Services	54

Allscripts	Computer Services	39
Allpayer Exchange	Computer Services	25
E-Health Technologies	Computer Services	17
Macquarie Technology Services	Computer Services	27
Optimizer	Other Prof Fees	76
D.J. Howard Appraisers	Other Prof Fees	69
Key Corporate Services	Other Prof Fees	231
Consolidated Land Surveying	Other Prof Fees	146
Alan Litwiller	Other Prof Fees	30
Registered Agent Solutions	Other Prof Fees	45
Duane Morris LLP	Other Prof Fees	12198
Marotta Gund Budd & Derza	Other Prof Fees	52546
Total (agree to Schedule V, line 19, column 8)		94,483

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6	N/A												
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,593** 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. $ **318,340**
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. $ **1,626**

(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. $ **6,123**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.