FOR BHF USE

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 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: 10/1/2005

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 1/1/2016 to 12/31/2016 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: 1/1/2016 Ending: 12/31/2016

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					8
9	SNF/PED					9
10	ICF	40,261	1,011		41,272	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,261	1,011		41,272	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.65%

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 10/1/2015 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: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	202,075	16,985	456	219,516		219,516	8,478	227,994			1
2	Food Purchase		247,972		247,972		247,972	(314)	247,658			2
3	Housekeeping	156,437	44,398		200,835		200,835	148	200,983			3
4	Laundry	57,948	16,092		74,040		74,040		74,040			4
5	Heat and Other Utilities			113,405	113,405		113,405	494	113,899			5
6	Maintenance	56,059	2,110	29,683	87,852		87,852	6,858	94,710			6
7	Other (specify):* Home Office Ben. Allocation											7
8	**TOTAL General Services**	472,519	327,557	143,544	943,620		943,620	15,664	959,284			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	1,732,890	93,014	9,635	1,835,539		1,835,539	(3,993)	1,831,546			10
10a	Therapy											10a
11	Activities	116,600	632	172	117,404		117,404	(1,222)	116,182			11
12	Social Services	136,021			136,021		136,021		136,021			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	**TOTAL Health Care and Programs**	1,985,511	93,646	24,807	2,103,964		2,103,964	(5,215)	2,098,749			16
	C. General Administration											
17	Administrative			374,200	374,200		374,200	(280,970)	93,230			17
18	Directors Fees											18
19	Professional Services			(1,460)	(1,460)		(1,460)	48,750	47,290			19
20	Dues, Fees, Subscriptions & Promotions			7,082	7,082		7,082	903	7,985			20
21	Clerical & General Office Expenses	57,230	6,987	16,234	80,451		80,451	106,635	187,086			21
22	Employee Benefits & Payroll Taxes			293,192	293,192		293,192	55,262	348,454			22
23	Inservice Training & Education							189	189			23
24	Travel and Seminar							92	92			24
25	Other Admin. Staff Transportation			4,029	4,029		4,029	7,775	11,804			25
26	Insurance-Prop.Liab.Malpractice			33,589	33,589		33,589	25,508	59,097			26
27	Other (specify):* Home Office Ben. Allocation											27
28	**TOTAL General Administration**	57,230	6,987	726,866	791,083		791,083	(35,856)	755,227			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,515,260	428,190	895,217	3,838,667		3,838,667	(25,407)	3,813,260			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: 1/1/2016 Ending: 12/31/2016

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			3,305	3,305		3,305	113,750	117,055			30
31	Amortization of Pre-Op. & Org.							14,290	14,290			31
32	Interest							146,532	146,532			32
33	Real Estate Taxes							84,683	84,683			33
34	Rent-Facility & Grounds			378,899	378,899		378,899	(378,899)				34
35	Rent-Equipment & Vehicles			43,035	43,035		43,035	1,778	44,813			35
36	Other (specify):*											36
37	**TOTAL Ownership**			425,239	425,239		425,239	(17,866)	407,373			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			321,325	321,325		321,325		321,325			42
43	Other (specify):*			37,409	37,409		37,409	(37,409)				43
44	**TOTAL Special Cost Centers**			358,734	358,734		358,734	(37,409)	321,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,515,260	428,190	1,679,190	4,622,640		4,622,640	(80,682)	4,541,958			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: 1/1/2016 Ending: 12/31/2016

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	(468)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,733)	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	1,803	30		9
10	Interest and Other Investment Income	(1,879)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(47)	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	(28,104)	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	(905)	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	(8,201)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (43,534)		$	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)	(52,401)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (52,401)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (95,935)		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

North Aurora Care Center

ID# 0047514

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Transportation Revenue	$ (1,222)	11	1
2	Offset Miscellaneous Income - Office Supplies	(115)	21	2
3	Offset Miscellaneous Income - Nursing Supplies	(4,244)	10	3
4	Offset Cable TV Revenue	(2,620)	43	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**	(8,201)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Aurora Care Center **#** 0047514 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	7,998	0	0	0	0	0	0	0	0	0	7,998	1
2	Food Purchase	(468)	13	0	0	0	0	0	0	0	0	0	(455)	2
3	Housekeeping	0	63	0	0	0	0	0	0	0	0	0	63	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	460	0	0	0	0	0	0	0	0	0	460	5
6	Maintenance	0	3,172	0	0	2,230	0	0	0	0	0	0	5,402	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(468)	11,706	0	0	2,230	0	0	0	0	0	0	13,468	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,244)	244	0	0	0	0	0	0	0	0	0	(4,000)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,222)	0	0	0	0	0	0	0	0	0	0	(1,222)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(5,466)	244	0	0	0	0	0	0	0	0	0	(5,222)	16
	C. General Administration													
17	Administrative	0	(280,970)	0	0	0	0	0	0	0	0	0	(280,970)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,148	0	68,932	4,320	0	0	0	0	0	0	87,400	19
20	Fees, Subscriptions & Promotions	0	0	254	0	0	0	0	0	0	0	0	254	20
21	Clerical & General Office Expenses	(115)	0	89,672	0	7,919	0	0	0	0	0	0	97,476	21
22	Employee Benefits & Payroll Taxes	0	0	59,969	0	0	0	0	0	0	0	0	59,969	22
23	Inservice Training & Education	0	0	617	0	0	0	0	0	0	0	0	617	23
24	Travel and Seminar	0	0	140	0	0	0	0	0	0	0	0	140	24
25	Other Admin. Staff Transportation	0	0	6,294	0	0	0	0	0	0	0	0	6,294	25
26	Insurance-Prop.Liab.Malpractice	0	0	967	0	24,413	0	0	0	0	0	0	25,380	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(115)	(266,822)	157,913	68,932	36,652	0	0	0	0	0	0	(3,440)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,049)	(254,872)	157,913	68,932	38,882	0	0	0	0	0	0	4,806	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Aurora Care Center # 0047514 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,803	0	14,365	4,304	87,319	0	0	0	0	0	0	107,791	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	9,236	0	0	0	0	0	0	9,236	31
32	Interest	(1,879)	0	463	161	113,352	0	0	0	0	0	0	112,097	32
33	Real Estate Taxes	0	0	1,048	0	84,180	0	0	0	0	0	0	85,228	33
34	Rent-Facility & Grounds	0	0	0	0	(378,899)	0	0	0	0	0	0	(378,899)	34
35	Rent-Equipment & Vehicles	0	0	1,215	0	0	0	0	0	0	0	0	1,215	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(76)	0	17,091	4,465	(84,812)	0	0	0	0	0	0	(63,332)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(37,409)	0	0	0	0	0	0	0	0	0	0	(37,409)	43
44	TOTAL Special Cost Centers	(37,409)	0	0	0	0	0	0	0	0	0	0	(37,409)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(43,534)	(254,872)	175,004	73,397	(45,930)	0	0	0	0	0	0	(95,935)	45

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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 Management, Inc.	100.00%	$ 7,998	$ 7,998	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	13	13	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	63	63	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	460	460	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,172	3,172	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%	244	244	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	374,200	Petersen Health Care Management, Inc.	100.00%	93,230	(280,970)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	14,148	14,148	12
13	V								13
14	Total			$ 374,200			$ 119,328	$ * (254,872)	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: 1/1/2016 Ending: 12/31/2016

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 Management, Inc.	100.00%	$ 254	$ 254	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	89,672	89,672	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	59,969	59,969	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	617	617	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	140	140	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	6,294	6,294	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	967	967	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	14,365	14,365	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	463	463	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	1,048	1,048	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	1,215	1,215	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			$			$ 175,004	$ * 175,004	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: 1/1/2016 Ending: 12/31/2016

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%	68,932	68,932	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0		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%	0		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%	4,304	4,304	33
34	V	31	Amortization		Petersen Health Operations, LLC	100.00%	0		34
35	V	32	Interest		Petersen Health Operations, LLC	100.00%	161	161	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			$			$ 73,397	$ * 73,397	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: 1/1/2016 Ending: 12/31/2016

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	6	Mainteance	$	North Aurora Land, LLC	100.00%	$ 2,230	$ 2,230	15
16	V	19	Professional Services	$	North Aurora Land, LLC	100.00%	4,320	4,320	16
17	V	21	Equipment		North Aurora Land, LLC	100.00%	7,919	7,919	17
18	V	26	Insurance-Property		North Aurora Land, LLC	100.00%	5,031	5,031	18
19	V	26	Insurance-Mortgage Insurance		North Aurora Land, LLC	100.00%	19,382	19,382	19
20	V	30	Depreciation		North Aurora Land, LLC	100.00%	87,319	87,319	20
21	V	31	Amortization		North Aurora Land, LLC	100.00%	9,236	9,236	21
22	V	32	Interest	1,459	North Aurora Land, LLC	100.00%	114,811	113,352	22
23	V	33	Real Estate Taxes		North Aurora Land, LLC	100.00%	84,180	84,180	23
24	V	34	Rent-Income and Grounds	378,899	North Aurora Land, LLC	100.00%		(378,899)	24
25	V					100.00%			25
26	V					100.00%			26
27	V					100.00%			27
28	V					100.00%			28
29	V					100.00%			29
30	V					100.00%			30
31	V					100.00%			31
32	V					100.00%			32
33	V					100.00%			33
34	V					100.00%			34
35	V					100.00%			35
36	V					100.00%			36
37	V					100.00%			37
38	V					100.00%			38
39	Total			$ 380,358			$ 334,428	$ * (45,930)	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: 1/1/2016 Ending: 12/31/2016

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 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 Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	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 North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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: 1/1/2016 Ending: 12/31/2016

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: 1/1/2016 Ending: 12/31/2016

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								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: 1/1/2016 Ending: 12/31/2016

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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 North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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	$ 301,135	$ 332,773	41,272	$ 7,998	1
2	2	Food	Resident Days	1,553,881	75	480	0	41,272	13	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,687	41,272	63	3
4	5	Utilities	Resident Days	1,553,881	75	17,327	0	41,272	460	4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	100,000	41,272	3,172	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	41,272	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	41,272	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192	2,054,132	41,272	244	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	41,272	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	41,272	0	10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	5,404,166	41,272	93,230	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666	0	41,272	14,148	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548	0	41,272	254	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,458,155	41,272	89,672	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	2,257,824	0	41,272	59,969	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223	0	41,272	617	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279	0	41,272	140	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965	0	41,272	6,294	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398	0	41,272	967	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	41,272	0	20
21	30	Depreciation	Resident Days	1,553,881	75	540,826	0	41,272	14,365	21
22	32	Interest	Resident Days	1,553,881	75	17,439	0	41,272	463	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471	0	41,272	1,048	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727	0	41,272	1,215	24
25	TOTALS					$ 12,370,446	$ 11,351,913		$ 294,332	25

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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	203,464	9	$	$	41,272	$	1
2	2	Food	Resident Days	203,464	9			41,272		2
3	3	Housekeeping	Resident Days	203,464	9			41,272		3
4	4	Laundry	Resident Days	203,464	9			41,272		4
5	5	Utilities	Resident Days	203,464	9			41,272		5
6	6	Maintenance	Resident Days	203,464	9			41,272		6
7	7	Mgmt. Allocation of Benefits	Resident Days	203,464	9			41,272		7
8	10	Nursing and Medical Records	Resident Days	203,464	9			41,272		8
9	15	Mgmt. Allocation of Benefits	Resident Days	203,464	9			41,272		9
10	17	Administrative	Resident Days	203,464	9			41,272		10
11	19	Professional Services	Resident Days	203,464	9	339,821		41,272	68,932	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	203,464	9			41,272		12
13	21	Clerical and General Office	Resident Days	203,464	9			41,272		13
14	22	Employee Benefits & Payroll	Resident Days	203,464	9			41,272		14
15	23	Inservice Training & Education	Resident Days	203,464	9			41,272		15
16	24	Travel and Seminar	Resident Days	203,464	9			41,272		16
17	25	Other Admin. Staff Transport.	Resident Days	203,464	9			41,272		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	203,464	9			41,272		18
19	30	Depreciation	Resident Days	203,464	9	21,216		41,272	4,304	19
20	31	Amortization	Resident Days	203,464	9			41,272		20
21	32	Interest	Resident Days	203,464	9	795		41,272	161	21
22	33	Real Estate Taxes	Resident Days	203,464	9			41,272		22
23	34	Rent-Facility and Grounds	Resident Days	203,464	9			41,272		23
24	35	Rent-Equipment & Vehicles	Resident Days	203,464	9			41,272		24
25	TOTALS					$ 361,832	$		$ 73,397	25

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 2/31/2016

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	$ 301,135	$ 332,773	41,272	$ 2,907	1
2	2	Food	Resident Days	1,553,881	75	480		41,272	5	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,362	2,687	41,272	23	3
4	5	Utilities	Resident Days	1,553,881	75	17,327		41,272		4
5	6	Maintenance	Resident Days	1,553,881	75	119,427	100,000	41,272	167	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			41,272	1,153	6
7	9	Medical Director	Resident Days	1,553,881	75			41,272		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	9,192	2,054,132	41,272	89	8
9	10A	Therapy	Resident Days	1,553,881	75			41,272		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			41,272		10
11	17	Administrative	Resident Days	1,553,881	75	4,799,018	5,404,166	41,272	58,879	11
12	19	Professional Services	Resident Days	1,553,881	75	532,666		41,272	5,142	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	9,548		41,272	92	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,376,139	3,458,155	41,272	32,589	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,553,881	75	2,257,824		41,272	21,794	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	23,223		41,272	224	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	5,279		41,272	51	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	236,965		41,272	2,287	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	36,398		41,272	351	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			41,272		20
21	30	Depreciation	Resident Days	1,553,881	75	540,826		41,272	5,220	21
22	32	Interest	Resident Days	1,553,881	75	17,439		41,272	168	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	39,471		41,272	381	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	45,727		41,272	441	24
25	TOTALS					$ 12,370,446	$ 11,351,913		$ 131,963	25

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	Capital Finance Group		X	Mortgage	Varies	9/15/14	$ 3,142,700	$ 2,937,400	12/31/34	Varies	$ 114,811	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,142,700	$ 2,937,400			$ 114,811	9
	B. Non-Facility Related*											
10								Interest Income Offset			(3,338)	10
11								Home Office Allocation-PHO			34,417	11
12								Home Office Allocation-PHCM			642	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 31,721	14
15	TOTALS (line 9+line14)						$ 3,142,700	$ 2,937,400			$ 146,532	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.)**

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	87,876	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.)	$	84,756	2
3. Under or (over) accrual (line 2 minus line 1).	$	(3,120)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)	$	87,300	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**		503	
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.	$	84,683	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	63,822	8
	2012	73,021	9
	2013	81,656	10
	2014	85,313	11
	2015	84,756	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(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	$ 84,609.12	$ 84,609.12
2.	12-34-331-005	Lot	$ 146.46	$ 146.46
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 84,755.58	$ 84,755.58

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 1/1/2016 Ending: 12/31/2016

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: 14,290 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: 1/1/2016 Ending: 12/31/2016

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	$ 607,610	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	15,000		15	1,000	1,000	11,500	9
10	Sidewalks			2006	23,280		15	1,552	1,552	16,296	10
11	Water Line Replacement			2006	3,775		25	151	151	1,586	11
12	Water Pump Replacement			2006	3,200		15	213	213	2,237	12
13	Fence			2007	6,150		15	410	410	3,895	13
14	Coil-Water Heater			2007	4,900		15	327	327	3,106	14
15	Compressor			2007	3,295		15	220	220	2,197	15
16	Employee Breakroom (Cabinets, Counter, Sink, Mouldings)			2007	2,976		15	198	198	1,832	16
17	Sprinkler repair			2008	3,782		20	190	190	1,615	17
18	Backflow preventer			2008	6,400		25	256	256	2,176	18
19	Renovations for bathrooms and tub rooms			2008	23,000		39	590	590	5,015	19
20	Fence			2009	8,270		15	552	552	4,140	20
21	Pipe Valve Repair			2009	4,406		7	311	311	4,406	21
22	Video Camera System			2009	7,357		5			7,357	22
23	Sprinkler System Installation			2009	25,768		20	1,288	1,288	9,660	23
24	Security Lock System			2009	12,131		5			12,131	24
25	Sprinkler Installation in Lower Level			2009	12,272		20	614	614	4,605	25
26	Fence			2010	3,663		15	244	244	1,586	26
27	Sprinkler System Repair			2010	8,354		15	556	556	3,614	27
28	A/C Unit			2010	2,625		15	176	176	1,144	28
29	Parking Lot			2010	183,686		25	7,415	7,415	54,704	29
30	Sprinkler System Repair			2011	5,987		7	856	856	4,708	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: 1/1/2016 Ending: 12/31/2016

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	$ 2,124	37
38	Boiler	2012	7,666		15	512	512	2,304	38
39	Fire Alarm Installation	2012	5,363		7	766	766	3,447	39
40	Water Main Repair	2012	3,933		7	562	562	1,967	40
41	Gutter and Soffit Replacement	2013	34,150		25	1,366	1,366	4,781	41
42	Air Conditioner	2014	2,851		15	190	190	475	42
43	Roof Replacement	2014	134,525		25	5,381	5,381	13,453	43
44	Fire Sprinkler Line Repair	2015	5,242		7	750	750	1,125	44
45	Air Conditioner-Kitchen	2016	2,534		7	181	181	181	45
46	8 Steel Doors and Window Frames	2016	14,836		7	1,060	1,060	1,060	46
47	Water Heater	2016	4,554		7	325	325	325	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			16,737			(16,737)		65
66									66
67	2016-Home Office Allocation-Building Improvements		18,222			437	437		67
68	2016-Home Office Allocation-Land Improvements		1,677			109	109		68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,922,630	$ 79,891		$ 81,770	$ 1,879	$ 798,362	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: 1/1/2016 Ending: 12/31/2016

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	$ 68,771	$ 5,601	$ 6,878	$ 1,277	5-10 yrs.	$ 43,978	71
72	Current Year Purchases	45,802	1,827	3,272	1,445	7 yrs.	3,272	72
73	Fully Depreciated Assets	292,405					292,405	73
74	Home Office Allocation			24,082	24,082			74
75	TOTALS	$ 406,978	$ 7,428	$ 34,232	$ 26,804		$ 339,655	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.	$ 4,741	76
77										77
78										78
79										79
80	TOTALS			$ 5,266	$	$ 1,053	$ 1,053		$ 4,741	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)	$ 2,406,874	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,319	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 117,055	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 29,736	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,142,758	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			93
94	N/A		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: 1/1/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 37,950 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 **1/1/2016**
Period End **12/31/2016**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 30,380
Dishwasher	705
Copier	5,087
Home Office Allocation	1,778
	37,950

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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: 1/1/2016 Ending: 12/31/2016

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.

Facility Name & ID Number North Aurora Care Center **#** 0047514 **Report Period Beginning:** 1/1/2016 **Ending:** 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2016 **(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	$ 23,338	$ 23,338	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 150,218)	2,105,649	2,105,649	3
4	Supply Inventory (priced at Cost)	16,424	16,424	4
5	Short-Term Investments			5
6	Prepaid Insurance	36,868	53,014	6
7	Other Prepaid Expenses		31,791	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Security Deposits	13,455	13,455	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,195,734	$ 2,243,671	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		1,331,722	14
15	Leasehold Improvements, at Historical Cost	3,150	590,908	15
16	Equipment, at Historical Cost	30,526	412,244	16
17	Accumulated Depreciation (book methods)	(7,810)	(1,142,758)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		203,196	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(20,781)	20
21	Restricted Funds		476,889	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 25,866	$ 1,923,420	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,221,600	$ 4,167,091	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 503,440	$ 503,440	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	129,374	129,374	30
31	Accrued Taxes Payable (excluding real estate taxes)	44,982	44,982	31
32	Accrued Real Estate Taxes(Sch.IX-B)		87,300	32
33	Accrued Interest Payable		9,424	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	549,574	549,574	36
37	Accrued Management Fees	33,114	33,114	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,260,484	$ 1,357,208	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,937,400	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	998,237	(134,277)	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 998,237	$ 2,803,123	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,258,721	$ 4,160,331	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (37,121)	$ 6,760	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,221,600	$ 4,167,091	48

***(See instructions.)**

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (762,302)	1
2	Restatements (describe):		2
3	**Prior Period Adjustments Made After Cost Report Was Filed**	(20,906)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (783,208)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	634,505	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	111,582	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)**	$ 746,087	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)**	$ (37,121)	24 *

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	$ 5,247,745	1
2	Discounts and Allowances for all Levels	(1,148)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,246,597	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	468	14
15	Telephone, Television and Radio	2,620	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)**	$ 3,088	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,879	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,879	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	1,222	28
28a	Miscellaneous Revenue	4,359	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,581	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,257,145	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	943,620	31
32	Health Care	2,103,964	32
33	General Administration	791,083	33
	B. Capital Expense		
34	Ownership	425,239	34
	C. Ancillary Expense		
35	Special Cost Centers	37,409	35
36	Provider Participation Fee	321,325	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,622,640	40
41	**Income before Income Taxes (line 30 minus line 40)****	634,505	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 634,505	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,175,674	44
45	Private Pay - Net Inpatient Revenue	70,923	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)	$ 5,246,597	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: 1/1/2016 Ending: 12/31/2016

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	1,955	1,955	$ 74,296	$ 38.00	1
2	Assistant Director of Nursing	2,080	2,080	67,173	32.29	2
3	Registered Nurses	6,694	6,774	229,949	33.95	3
4	Licensed Practical Nurses	17,815	18,375	540,824	29.43	4
5	CNAs & Orderlies	45,815	48,174	693,136	14.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	30,128	14.48	9
10	Activity Assistants	3,642	3,700	37,622	10.17	10
11	Social Service Workers	6,784	6,904	136,021	19.70	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,445	14.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,899	15,045	171,630	11.41	15
16	Dishwashers					16
17	Maintenance Workers	4,462	4,542	56,059	12.34	17
18	Housekeepers	13,103	13,713	156,437	11.41	18
19	Laundry	5,827	6,015	57,948	9.63	19
20	Administrator	2,080	2,080	93,230	44.82	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,876	4,076	57,230	14.04	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: CPC	4,063	4,135	127,512	30.84	32
33	Other(specify) Transportation	2,032	2,184	48,850	22.37	33
34	TOTAL (lines 1 - 33)	138,287	143,912	$ 2,608,490 *	$ 18.13	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	8	$ 456	L1, C3	35
36	Medical Director	Monthly	15,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,997	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	10	578	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)	17	$ 25,031		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	2	60	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	2	$ 60		53

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ken Bogard	Administrator	0	$ 93,230
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 93,230

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 374,200
TOTAL (agree to Schedule V, line 17, col. 3)	$ 374,200
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 849
AT&T	Internet Services	80
Comcast	Internet Services	1,256
Honkamp Kruger	Accounting Services	640
TCF National Bank	Copying Fees	35
Capitol Finance Group	Refund of Refiance Fees	(4,320)
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ (1,460)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,071
Unemployment Compensation Insurance	48,969
FICA Taxes	190,284
Employee Health Insurance	7,212
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,862
Employee Retirement	794
Home Office Allocation	55,262
TOTAL (agree to Schedule V, line 22, col.8)	$ 348,454

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	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 9)	254
Patient Background Checks 47	1,333
Miscellaneous Licenses & Permits	1,106
Miscellaneous Dues & Subscriptions	4,389
Home Office Allocation	903
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,985

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	92
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 92

**See instructions.

North Aurora Care Center
0047514
Period Beginning **1/1/2016**
Period End **12/31/2016**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		(1,460)
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	96
Miscellaneous	Legal	35
Miller Hall and Triggs	Legal	167
Healthcare Resources International	Legal	832
Hunziker Law	Legal	199
Lexis Nexis	Legal	17
Illinois Secretary of State	Legal	58
Lane and Waterman	Legal	340
Quinn and Johnston	Legal	1,510
Peoria County Recorder	Legal	42
Capital Finance Group	Legal	250
CliftonLarson Allen	Accountants	865
Ginoli & Co.	Accountants	12,030
Capital Finance Group	Accountants	6,779
Miscellaneous	Computer Services	110
Change Healthcare	Computer Services	16
PTC Select	Computer Services	10
Advanced Answers on Demand	Computer Services	7,600
Stratus Networks	Computer Services	773
Kemper Technology	Computer Services	509
AT&T	Computer Services	11
Ability Network	Computer Services	3,240
CIAN	Computer Services	386
Comcast	Computer Services	63
CCH	Computer Services	25
Charter Communications	Computer Services	75
Allscripts	Computer Services	1,130
ATS	Computer Services	510
Allpayer Exchange	Computer Services	26
Optimizer	Other Prof Fees	78
Ankura	Other Prof Fees	590
David Budde	Other Prof Fees	67
Bruner, Cooper, Zuck	Other Prof Fees	172
Marotta, Gund, Budd, Dzerda	Other Prof Fees	10,040
Professional Software and Services	Other Prof Fees	42
Hughes Valuation Services	Other Prof Fees	53
Alan Litwiller	Other Prof Fees	4
Total (agree to Schedule V, line 19, column 8)		47,290

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $4389**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,250** 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. $ **321,325**
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. $ **468**

(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. $ **1,222**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Det	-95,935	equal to	-80,682	-15,253	FAILED	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expens	146,532	equal to	146,532	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	84,683	equal to	84,683	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp	14,290	equal to	14,290	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	117,055	equal to	117,055	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	44,813	equal to	44,813	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service		equal to	0	#VALUE!	#VALUE!	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- S		equal to	0	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	943,620	equal to	943,620	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	2,103,964	equal to	2,103,964	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	791,083	equal to	791,083	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	425,239	equal to	425,239	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	37,409	equal to	37,409	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Pr	321,325	equal to	321,325	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,732,890	equal to	1,732,890	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aid	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	116,600	equal to	116,600	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Se	136,021	equal to	136,021	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	202,075	equal to	202,075	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	56,059	equal to	56,059	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	156,437	equal to	156,437	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	57,948	equal to	57,948	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administra	93,230	equal to	93,230	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	57,230	equal to	57,230	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	2,608,490	equal to	2,515,260	93,230	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consulta	456	< or = to	456	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Directo	15,000	< or = to	15,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	9,635	< or = to	9,635	0	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consulta	0	< or = to	172	-172	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	93,230	equal to	93,230	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	374,200	equal to	374,200	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	-1,460	equal to	-1,460	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	348,454	equal to	348,454	0	FAILED	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	7,985	equal to	7,985	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	92	equal to	92	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	321,325	equal to	321,325	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medica	0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	-52,401	equal to	-52,401	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balan	2,937,400	equal to	2,937,400	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax	87,300	equal to	87,300	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	72,000	equal to	72,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,922,630	equal to	1,922,630	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and	412,244	equal to	412,244	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	1,142,758	equal to	1,142,758	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	-37,121	equal to	-37,121	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	634,505	equal to	634,505	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,221,600	equal to	2,221,600	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

Enter Cost Cen **YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINKED TO THE COST REPORT!!!!** 7/7/2017 11:22:47 AM

HSA Number:	4	Name:	North Aurora Care Center		
Cost report peri From:	1/1/2016	To:	12/31/2016	Base Number:	492
If this is an ICF/DD 16 facility, e	N				
Licensed bed d	47,085	Occupancy:	41,272	Pct. of occupan	87.65%

ıblic Aid Support Rate: $ ________

Genl Services S	472,519	Col 1, Line 8 ---Audit Adj:	________
Genl Admin Sal	57,230	Col 1, Line 28 ---Audit Adj:	________
Total Salary Wa	2,515,260	Col 1, Line 44 ---Audit Adj:	________
Employee Bene	348,454	Col 8, Line 22 ---Audit Adj:	________
Total General S	959,284	Col 8, Line 8 ---Audit Adj:	________
Total General A	755,227	Col 8, Line 28 ---Audit Adj:	________

Instructions and Calculation Steps

STEP I Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes.

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration.

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to you total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8)	$472,519
Divided by Total Wages (Column 1, Line 44)	$2,515,260
General service wages as percent of total wages	18.7861%
Employee Benefits (Column 10, Line 22)	$348,454
Allocation of Employee Benefits to General Services Costs	$65,461
Plus Total General Services (Column 10, Line 8)	$959,284
New Total General Services Cost	$1,024,745

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringes amount for General Administration.

3 Add the proportioned fringe amount to your total General Administration expenses.

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost.

General Administration Wages (Column 1, Line 28).	$57,230
Divided by Total Wages (Column 1, Line 45)	$2,515,260
General administration wages as a percent of total wages	2.2753%
Employee Benefits (Column 10, Line 22)	$348,454
Allocation of Emplayee Benefits to General Admin. Costs	$7,928
Plus Total General Administration (Column 10, Line 28)	$755,227
Minus Total Fringe (Column 10, Line 22)	$348,454
New Total General Administration Cost	$414,701

STEP II Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Mon	13	divided by 2 =	6.5
Beginning Day + Ending Day =	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	232	multiplied by 6 =	1392
Sum of the three lines			1399.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			492

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier:	1
General Administration Multiplier:	1

C. Apply Inflation Multipliers to Update Cost

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-A)	$1,024,745	
General Services Multiplier (Step II-B)	1	
Updated General Services Cost		$1,024,745

2 Multiply New Total General Administration Cost (from Step I-B)by the appropriate multiplier from Table I:

New Total General Service Cost (Step I-B)	$414,701	
General Administration Multiplier (Step II-B)	1	
Updated General Services Cost		$414,701

3 Total Updated Support Costs (1 + 2) $1,439,446

STEP III Convert Total Updated Support Costs (C-3) to Per Diem Costs

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT COSTS $34.18

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14).

Total Support Costs (Step II, C, 3, above)	$1,439,446
Total Patient Days (Cost Report)	41,272
Support Costs per Diem	$34.88

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A, Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above) by your adjusted occupancy.

Licensed Bed Days	47,085
Multiplied by	0.93
	43,789
Minus total Patient Days	41,272
	2,517
One-third of difference	839
Plus Total Patient Days	41,272
Adjusted Occupancy	42,111
Total Support Costs (Step II, C, 3, above)	$1,439,446
Divided by Adjusted Occupany	42111
Support Costs Per Diem	$34.18

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA. Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table II.

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$34.18
Difference	$13.26
Multiply the Difference by	0.5
One-Half of the Difference	$6.63
Plus Support Costs Per Diem	$34.18
Support Rate if costs are between 35th and 75th percentile	40.81

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate:

75 Percentile Rate for your HSA	$47.44
Minus Support Costs Per Diem	$34.18
Difference	$13.26
Multiply the Difference by	0.5
One-Half of the Difference	$6.63
Compare one-half the difference to the profit ceiling for your HSA in Table II and	3.795
Enter the Lower of the Two Amounts	$3.795
Plus Support Costs Per Diem	$34.18
Support Rate if support costs less than 35th percentile	$37.98

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C above **$37.98**

75th Percentile is	$47.44
35th Percentile is	$39.95

Table I
Inflation Multipliers

Base Number	General Services Multiplier	General Administration Multiplier
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table II
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	48.45	39.86	4.345
2	47.44	39.95	3.795
3	41.84	34.67	3.635
4	47.44	39.95	3.795
5	41.31	34.45	3.645
6	52.64	38.99	6.875
7	52.64	38.99	6.875
8	52.64	38.99	6.875
9	49.92	38.30	5.860
10	48.45	39.86	4.345
11	43.93	35.79	4.120

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA
Not updated with current figures

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	202,075	16,985	456	219,516	0	219,516	8,478	227,994
2. Food Purchase	0	247,972	0	247,972	0	247,972	-314	247,658
3. Housekeeping	156,437	44,398	0	200,835	0	200,835	148	200,983
4. Laundry	57,948	16,092	0	74,040	0	74,040	0	74,040
5. Heat and Other Utilities	0	0	113,405	113,405	0	113,405	494	113,899
6. Maintenance	56,059	2,110	29,683	87,852	0	87,852	6,858	94,710
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	472,519	327,557	143,544	943,620	0	943,620	15,664	959,284
9. Medical Director	0	0	15,000	15,000	0	15,000	0	15,000
10. Nursing & Medical Records	1,732,890	93,014	9,635	1,835,539	0	1,835,539	-3,993	#######
10a. Therapy	0	0	0	0	0	0	0	0
11. Activities	116,600	632	172	117,404	0	117,404	-1,222	116,182
12. Social Services	136,021	0	0	136,021	0	136,021	0	136,021
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,985,511	93,646	24,807	2,103,964	0	2,103,964	-5,215	#######
17. Administrative	0	0	374,200	374,200	0	374,200	-280,970	93,230
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	-1,460	-1,460	0	-1,460	48,750	47,290
20. Fees, Subscriptions & Promotion	0	0	7,082	7,082	0	7,082	903	7,985
21. Clerical & General Office	57,230	6,987	16,234	80,451	0	80,451	106,635	187,086
22. Employee Benefits & Payroll	0	0	293,192	293,192	0	293,192	55,262	348,454
23. Inservice Training & Education	0	0	0	0	0	0	189	189
24. Travel and Seminar	0	0	0	0	0	0	92	92
25. Other Admin. Staff Trans	0	0	4,029	4,029	0	4,029	7,775	11,804
26. Insurance-Prop.Liab.Malpractice	0	0	33,589	33,589	0	33,589	25,508	59,097
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	57,230	6,987	726,866	791,083	0	791,083	-35,856	755,227
29. Total General Administrative	2,515,260	428,190	895,217	3,838,667	0	3,838,667	-25,407	#######
30. Depreciation	0	0	3,305	3,305	0	3,305	113,750	117,055
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	14,290	14,290
32. Interest	0	0	0	0	0	0	146,532	146,532
33. Real Estate	0	0	0	0	0	0	84,683	84,683
34. Rent - Facility & Grounds	0	0	378,899	378,899	0	378,899	-378,899	0
35. Rent - Equipment & Vehicles	0	0	43,035	43,035	0	43,035	1,778	44,813
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	425,239	425,239	0	425,239	-17,866	407,373
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	321,325	321,325	0	321,325	0	321,325
43. Other (specify):*	0	0	37,409	37,409	0	37,409	-37,409	0
44. Total Special Cost Ce	0	0	358,734	358,734	0	358,734	-37,409	321,325
45. Grand Total	2,515,260	428,190	1,679,190	4,622,640	0	4,622,640	-80,682	#######

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	23,338	23,338
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	2,105,649	2,105,649
4. Supply Inventory	16,424	16,424
5. Short-Term Investments	0	0
6. Prepaid Insurance	36,868	53,014
7. Other Prepaid Expenses	0	31,791
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	13,455	13,455
10. Total current assets	2,195,734	2,243,671
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	72,000
14. Buildings, at Historical Cost	0	1,331,722
15. Leasehold Improvements, Historical Cost	3,150	590,908
16. Equipment, at Historical Cost	30,526	412,244
17. Accumulated Depreciation (book methods)	-7,810	-1,142,758
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	203,196
20. Accum Amort - Org/Pre-Op Costs	0	-20,781
21. Restricted Funds	0	476,889
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	25,866	1,923,420
25. Total Assets	2,221,600	4,167,091
CURRENT LIABILITIES		
26. Accounts Payable	503,440	503,440
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	129,374	129,374
31. Accrued Taxes Payable	44,982	44,982
32. Accrued Real Estate Taxes	0	87,300
33. Accrued Interest Payable	0	9,424
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	549,574	549,574
37. Other Current Liabilities (specify):	33,114	33,114
38. Total Current Liabilities	1,260,484	1,357,208
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	2,937,400
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	998,237	-134,277
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	998,237	2,803,123
46.Total Liabilities	2,258,721	4,160,331
47.Total Equity	-37,121	6,760
48.Total Liabilities and Equity	2,221,600	4,167,091

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,247,745
2. Discounts and Allowances for all Levels	-1,148
Subtotal - Inpatient Care	5,246,597
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	468
15. Telephone, Television, and Radio	2,620
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	3,088
24. Contributions	0
25. Interest and Other Investments Income	1,879
Subtotal - Non-Operating Revenue	1,879
27. Other Revenue (specify):	1,222
28. Other Revenue (specify):	4,359
Subtotal - Other Revenue	5,581
30. Total Revenue	5,257,145
31. General Services	950,433
32. Health Care	2,022,601
33. General Administration	831,319
34. Ownership	461,485
35. Special Cost Centers	172,095
35. Provider Participation Fee	318,340
37. Other	0
40. Total Expenses	4,756,273
41. Income Before Income Taxes	500,872
42. Income Taxes	0
43. Net Income or Loss for the Year	500,872