



Facility Name & ID Number North Aurora Care Center

# 0047514 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	39,367	1,962		41,329	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,367	1,962		41,329	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.78%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO  Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?  
Date started 10/01/05

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 10/01/05 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

Is your fiscal year identical to your tax year? YES  NO

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	160,685	17,073	2,352	180,110		180,110	8,321	188,431		1
2	Food Purchase		199,336		199,336		199,336	118	199,454		2
3	Housekeeping	94,414	28,092		122,506		122,506	39	122,545		3
4	Laundry	42,825	14,336		57,161		57,161	2	57,163		4
5	Heat and Other Utilities			91,765	91,765		91,765	591	92,356		5
6	Maintenance	29,128	14,916	26,489	70,533		70,533	4,852	75,385		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							5,634	5,634		7
8	<b>TOTAL General Services</b>	327,052	273,753	120,606	721,411		721,411	19,557	740,968		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,277,958	41,440	1,025	1,320,423		1,320,423	14,859	1,335,282		10
10a	Therapy			862	862		862		862		10a
11	Activities	65,144	2,639	802	68,585		68,585		68,585		11
12	Social Services	109,200	626		109,826		109,826		109,826		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							6,788	6,788		15
16	<b>TOTAL Health Care and Programs</b>	1,452,302	44,705	13,489	1,510,496		1,510,496	21,647	1,532,143		16
	<b>C. General Administration</b>										
17	Administrative	113,904		142,500	256,404		256,404	(96,889)	159,515		17
18	Directors Fees										18
19	Professional Services			14,446	14,446		14,446	12,727	27,173		19
20	Dues, Fees, Subscriptions & Promotions			9,078	9,078		9,078	1,643	10,721		20
21	Clerical & General Office Expenses	27,939	7,181	16,559	51,679		51,679	63,744	115,423		21
22	Employee Benefits & Payroll Taxes			235,721	235,721		235,721		235,721		22
23	Inservice Training & Education			26	26		26	674	700		23
24	Travel and Seminar							1,074	1,074		24
25	Other Admin. Staff Transportation			6,642	6,642		6,642	6,993	13,635		25
26	Insurance-Prop.Liab.Malpractice			25,844	25,844		25,844	1,583	27,427		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							33,333	33,333		27
28	<b>TOTAL General Administration</b>	141,843	7,181	450,816	599,840		599,840	24,882	624,722		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,921,197	325,639	584,911	2,831,747		2,831,747	66,086	2,897,833		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:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			103,024	103,024		103,024	2,526	105,550			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			283,490	283,490		283,490	94,746	378,236			32
33	Real Estate Taxes			40,363	40,363		40,363	1,353	41,716			33
34	Rent-Facility & Grounds							83	83			34
35	Rent-Equipment & Vehicles			5,035	5,035		5,035	1,089	6,124			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			431,912	431,912		431,912	99,797	531,709			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		20		20		20		20			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			70,628	70,628		70,628		70,628			42
43	Other (specify):* Non-allowable Cost	5,077	7	(28,981)	(23,897)		(23,897)	23,897				43
44	<b>TOTAL Special Cost Centers</b>	5,077	27	41,647	46,751		46,751	23,897	70,648			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,926,274	325,666	1,058,470	3,310,410		3,310,410	189,780	3,500,190			45

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

\*\*See schedule of adjustments attached at end of cost report.

Facility Name & ID Number North Aurora Care Center

# 0047514

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,085)	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	(3,924)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(882)	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				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	35,024	43		24
25	Fund Raising, Advertising and Promotional	(7,060)	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 <u>See Pg. 5A</u>	(2,563)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ 19,509		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	170,271	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 170,271		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 189,780		37

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

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

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

North Aurora Care Center

ID# 0047514

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (400)	43	1
2	Offset Miscellaneous Office Supplies Revenue	(463)	21	2
3	Disallowed Special Events	(1,700)	43	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	<b>Total</b>	(2,563)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Aurora Care Center# 0047514

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	3,458	0	4,863	0	0	0	0	0	0	0	8,321	1
2	Food Purchase	(1)	119	0	0	0	0	0	0	0	0	0	118	2
3	Housekeeping	0	39	0	0	0	0	0	0	0	0	0	39	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	591	0	0	0	0	0	0	0	0	0	591	5
6	Maintenance	0	4,818	0	34	0	0	0	0	0	0	0	4,852	6
7	Other (specify):*	0	1,578	0	4,056	0	0	0	0	0	0	0	5,634	7
8	<b>TOTAL General Services</b>	<b>(1)</b>	<b>10,605</b>	<b>0</b>	<b>8,953</b>	<b>0</b>	<b>19,557</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	9,145	0	5,714	0	0	0	0	0	0	0	14,859	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	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	2,033	0	4,755	0	0	0	0	0	0	0	6,788	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>11,178</b>	<b>0</b>	<b>10,469</b>	<b>0</b>	<b>21,647</b>	<b>16</b>						
	<b>C. General Administration</b>													
17	Administrative	0	(116,755)	0	19,866	0	0	0	0	0	0	0	(96,889)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,989	0	5,738	0	0	0	0	0	0	0	12,727	19
20	Fees, Subscriptions & Promotions	0	0	1,514	129	0	0	0	0	0	0	0	1,643	20
21	Clerical & General Office Expenses	(463)	0	58,622	5,585	0	0	0	0	0	0	0	63,744	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	674	0	0	0	0	0	0	0	0	674	23
24	Travel and Seminar	0	0	1,073	1	0	0	0	0	0	0	0	1,074	24
25	Other Admin. Staff Transportation	0	0	3,888	3,105	0	0	0	0	0	0	0	6,993	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,583	0	0	0	0	0	0	0	0	1,583	26
27	Other (specify):*	0	0	16,762	16,571	0	0	0	0	0	0	0	33,333	27
28	<b>TOTAL General Administration</b>	<b>(463)</b>	<b>(109,766)</b>	<b>84,116</b>	<b>50,995</b>	<b>0</b>	<b>24,882</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(464)</b>	<b>(87,983)</b>	<b>84,116</b>	<b>70,417</b>	<b>0</b>	<b>66,086</b>	<b>29</b>						

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Aurora Care Center# 0047514

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## 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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(3,924)	0	4,105	2,345	0	0	0	0	0	0	0	2,526	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	7,135	87,611	0	0	0	0	0	0	0	94,746	32
33	Real Estate Taxes	0	0	1,353	0	0	0	0	0	0	0	0	1,353	33
34	Rent-Facility & Grounds	0	0	83	0	0	0	0	0	0	0	0	83	34
35	Rent-Equipment & Vehicles	0	0	1,089	0	0	0	0	0	0	0	0	1,089	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(3,924)</b>	<b>0</b>	<b>13,765</b>	<b>89,956</b>	<b>0</b>	<b>99,797</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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):*	23,897	0	0	0	0	0	0	0	0	0	0	23,897	43
44	<b>TOTAL Special Cost Centers</b>	<b>23,897</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>23,897</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>19,509</b>	<b>(87,983)</b>	<b>97,881</b>	<b>160,373</b>	<b>0</b>	<b>189,780</b>	<b>45</b>						

Facility Name & ID Number

North Aurora Care Center

# 0047514

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen		See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,458	\$ 3,458	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	119	119	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	39	39	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	591	591	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,818	4,818	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,578	1,578	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	9,145	9,145	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,033	2,033	10
11	V	17 Administrative	142,500	Petersen Health Care, Inc.	100.00%	25,745	(116,755)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,989	6,989	12
13	V							13
14	Total		\$ 142,500			\$ 54,517	\$ * (87,983)	14

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,514	\$	1,514	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	58,622		58,622	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	674		674	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,073		1,073	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,888		3,888	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,583		1,583	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	16,762		16,762	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,105		4,105	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	7,135		7,135	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,353		1,353	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	83		83	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,089		1,089	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	<b>Total</b>		\$			\$ 97,881	\$ *	97,881	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Operations, LLC	100.00%	\$ 4,863	\$ 4,863	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0	0	16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0	0	17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0	0	18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0	0	19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	34	34	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	4,056	4,056	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	5,714	5,714	22
23	V	10A Therapy		Petersen Health Operations, LLC	100.00%	0	0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	4,755	4,755	24
25	V	17 Administrative		Petersen Health Operations, LLC	100.00%	19,866	19,866	25
26	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	5,738	5,738	26
27	V	20 Dues, Fees, Subs and Promotions		Petersen Health Operations, LLC	100.00%	129	129	27
28	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	5,585	5,585	28
29	V	23 Inservice Training and Education		Petersen Health Operations, LLC	100.00%	0	0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	1	1	30
31	V	25 Other Admin. Staff Transportation		Petersen Health Operations, LLC	100.00%	3,105	3,105	31
32	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Operations, LLC	100.00%	0	0	32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	16,571	16,571	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	2,345	2,345	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	87,611	87,611	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0	0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0	0	37
38	V	35 Rent-Equipment and Vehicles		Petersen Health Operations, LLC	100.00%	0	0	38
39	Total		\$			\$ 160,373	\$ * 160,373	39

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

Facility Name &amp; ID Number

North Aurora Care Center

# 0047514

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.69	3.08	Salary	\$ 25,745	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 25,745		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: 01/01/2007 Ending: 2/31/2007

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	41,329	\$ 3,458	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	41,329	119	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	41,329	39	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	41,329	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	41,329	591	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	41,329	4,818	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	41,329	1,578	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	41,329	9,145	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	41,329	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	41,329	2,033	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	41,329	25,745	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	41,329	6,989	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	41,329	1,514	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	41,329	58,622	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	41,329	674	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	41,329	1,073	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	41,329	3,888	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	41,329	1,583	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	41,329	16,762	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	41,329	4,105	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	41,329	7,135	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	41,329	1,353	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	41,329	83	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	41,329	1,089	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 152,398	25

Facility Name & ID Number North Aurora Care Center

# 0047514

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES  NO

Name of Related Organization Petersen Health 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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	440,525	23	\$ 51,832	\$ 51,832	41,329	\$ 4,863	1
2	2	Food	Resident Days	440,525	23			41,329		2
3	3	Housekeeping	Resident Days	440,525	23			41,329		3
4	4	Laundry	Resident Days	440,525	23			41,329		4
5	5	Utilities	Resident Days	440,525	23			41,329		5
6	6	Maintenance	Resident Days	440,525	23	358		41,329	34	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		41,329	4,056	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	41,329	5,714	8
9	10A	Therapy	Resident Days	440,525	23			41,329		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		41,329	4,755	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	41,329	19,866	11
12	19	Professional Services	Resident Days	440,525	23	61,162		41,329	5,738	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		41,329	129	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		41,329	5,585	14
15	23	Inservice Training & Education	Resident Days	440,525	23			41,329		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		41,329	1	16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		41,329	3,105	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			41,329		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		41,329	16,571	19
20	30	Depreciation	Resident Days	440,525	23	24,996		41,329	2,345	20
21	32	Interest	Resident Days	440,525	23	933,842		41,329	87,611	21
22	33	Real Estate Taxes	Resident Days	440,525	23			41,329		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			41,329		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			41,329		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 160,373	25

Facility Name & ID Number North Aurora Care Center

# 0047514

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1	LaSalle Bank		X	Mortgage	Varies	09/30/05	\$ 4,250,000	\$ 4,222,283	12/31/13	Varies	\$ 283,490	1								
2												2								
3							Home Office Allocation-PHO				87,611	3								
4							Home Office Allocation-PHC				7,135	4								
5												5								
<b>Working Capital</b>																				
6												6								
7												7								
8												8								
9	<b>TOTAL Facility Related</b>						\$ 4,250,000	\$ 4,222,283			\$ 378,236	9								
<b>B. Non-Facility Related*</b>																				
10												10								
11												11								
12												12								
13												13								
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14								
15	<b>TOTALS (line 9+line14)</b>						\$ 4,250,000	\$ 4,222,283			\$ 378,236	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.      \$ None                      Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2006 report.		\$	<b>38,200</b>	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.)	2006	\$	<b>38,563</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>363</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>40,000</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		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. <b>Home Office Allocation</b>		\$	<b>1,353</b>	
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>41,716</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002		8	
	2003		9	
	2004		10	
	2005	<b>38,117</b>	11	
	2006	<b>38,563</b>	12	
<b>Accrual based on prior year tax bill.</b>				
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2006 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME North Aurora Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047514

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>                    </u>	<u>Long-Term Care Facility</u>	\$ <u>38,563.00</u>	\$ <u>                    </u>
2. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                    </u>	<u>                                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>		\$ <u>38,563.00</u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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:

01/01/2007 Ending:

12/31/2007

**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?  (a) Own the Facility  (b) Rent from a Related Organization.  (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?  YES  NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>27,812</u>	<u>2005</u>	<u>\$ 72,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>27,812</b>		<b>\$ 72,000</b>	<b>3</b>

Facility Name &amp; ID Number North Aurora Care Center

# 0047514

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	129	2005	1972	\$ 1,298,500	\$	25	\$ 51,940	\$ 51,940	\$ 129,850	4
5										5
6										6
7	Home Office Allocation			23,041			563	563		7
8										8
	<b>Improvement Type**</b>									
9										9
10	Original Land Improvements	2005		15,000		15	1,000	1,000	2,500	10
11	Sidewalks	2006		23,280		15	1,552	1,552	2,328	11
12	New Wall In	2006		2,425		25	97	97	146	12
13	Water Line Replacement	2006		3,775		25	151	151	227	13
14	Water Pump Replacement	2006		3,200		15	213	213	320	14
15	Fence	2007		6,150		15	205	205	205	15
16	Fire Door	2007		1,843		15	61	61	61	16
17	3 Bathrooms-Construction and Demolition	2007		19,710		15	506	506	506	17
18	Coil-Water Heater	2007		4,900		15	163	163	163	18
19	Compressor	2007		3,295		15	110	110	110	19
20	Employee Breakroom (Cabinets, Counter, Sink, Mouldings)	2007		2,976		15	50	50	50	20
21										21
22										22
23										23
24	Building Booked				51,981			(51,981)		24
25	Building Improvement Booked				3,964			(3,964)		25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			1,542			92	92		31
32										32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								41				
42								42				
43								43				
44								44				
45								45				
46								46				
47								47				
48								48				
49								49				
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66								66				
67								67				
68								68				
69								69				
70	TOTAL (lines 4 thru 69)	\$	1,409,637	\$	55,945	\$	56,703	\$	758	\$	136,466	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:

01/01/2007

Ending:

12/31/2007

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 286,556	\$ 44,066	\$ 41,920	\$ (2,146)	3-10	\$ 105,456	71
72	Current Year Purchases	22,644	3,013	1,132	(1,881)	10	1,132	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			5,795	5,795			74
75	TOTALS	\$ 309,200	\$ 47,079	\$ 48,847	\$ 1,768		\$ 106,588	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,790,837	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 103,024	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 105,550	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 2,526	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 243,054	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>83</u>			6
7	TOTAL				\$ <u>83</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. \_\_\_\_\_

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

YES  NO

16. Rental Amount for movable equipment: \$ 6,124 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2009 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2010 \$ \_\_\_\_\_

\* 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 01/01/2007**

**Period End 12/31/2007**

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$	16
Dishwasher		1,030
Maintenance Equipment		66
Copier		3,923
Home Office Allocation		1,089
		<u>6,124</u>

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
10	<b>SUM OF line 9, col. 1 and 2 (e)</b>	\$			

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	23	\$ 347	\$	23	\$ 347	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2	33		2	33	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		32	482		32	482	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				20		20	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	57	\$ 862	\$ 20	57	\$ 882	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 &amp; ID Number North Aurora Care Center

# 0047514

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 3,167,358	\$ 3,167,358	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	1,077,650	1,077,650	3
4	Supply Inventory (priced at <u>                    </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,944	19,944	6
7	Other Prepaid Expenses	3,043	3,043	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>                                    </u>			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,267,995	\$ 4,267,995	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	116,430	72,000	13
14	Buildings, at Historical Cost	1,298,500	1,321,541	14
15	Leasehold Improvements, at Historical Cost	36,126	88,096	15
16	Equipment, at Historical Cost	308,223	309,200	16
17	Accumulated Depreciation (book methods)	(219,828)	(243,054)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>                                    </u>			22
23	Other(specify): <u>                                    </u>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,539,451	\$ 1,547,783	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 5,807,446	\$ 5,815,778	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 175,771	\$ 175,771	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,477	35,477	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,139	7,139	31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,000	40,000	32
33	Accrued Interest Payable	26,385	26,385	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	36,636	36,636	36
37	<u>Due to Related Parties</u>	117,304	117,304	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 438,712	\$ 438,712	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,222,283	4,222,283	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>  </u>			43
44	<u>  </u>			44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 4,222,283	\$ 4,222,283	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 4,660,995	\$ 4,660,995	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,146,451	\$ 1,154,783	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 5,807,446	\$ 5,815,778	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>679,632</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Post Cost Report Audit Adjustments</b>	<b>(60,240)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>619,392</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>527,059</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>527,059</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,146,451</b>	<b>24</b> *

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

North Aurora Care Center  
0047514  
Period Beginning 01/01/2007  
Period End 12/31/2007

**Schedule 18A**

**XVI. Statement of Changes in Equity**

**Beginning Equity Restatements:**

**Post Cost Report Audit Adjustments**

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,837,005	1
2	Discounts and Allowances for all Levels		2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,837,005	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Miscellaneous Revenue</u>	463	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 463	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 3,837,469	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	721,411	31
32	Health Care	1,510,496	32
33	General Administration	599,840	33
	<b>B. Capital Expense</b>		
34	Ownership	431,912	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	(23,877)	35
36	Provider Participation Fee	70,628	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 3,310,410	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	527,059	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 527,059	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

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

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

Facility Name & ID Number North Aurora Care Center

# 0047514

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 74,923	\$ 36.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,216	10,447	300,158	28.73	3
4	Licensed Practical Nurses	10,662	11,154	276,920	24.83	4
5	CNAs & Orderlies	44,944	47,069	625,957	13.30	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,953	1,961	29,355	14.97	9
10	Activity Assistants	3,437	3,548	35,789	10.09	10
11	Social Service Workers	7,393	7,500	109,200	14.56	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,917	16.79	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,703	14,143	125,768	8.89	15
16	Dishwashers					16
17	Maintenance Workers	2,274	2,377	29,128	12.25	17
18	Housekeepers	10,764	11,061	94,414	8.54	18
19	Laundry	5,221	5,429	42,825	7.89	19
20	Administrator	2,057	2,207	113,904	51.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,035	2,075	27,939	13.46	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 Care(specify)					32
33	Other(specify) <u>Marketing</u>	563	563	5,077	9.02	33
34	TOTAL (lines 1 - 33)	119,382	123,694	\$ 1,926,274 *	\$ 15.57	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	45 hours	\$ 2,352	1(3)	35
36	Medical Director	Monthly	10,800	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,025	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 14,177		49

**C. CONTRACT NURSES**

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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
<u>Quinn Corcoran</u>	<u>Administrator</u>	<u>0</u>	\$ <u>31,960</u>	<u>Workers' Compensation Insurance</u>	\$ <u>27,098</u>	<u>IDPH License Fee</u>	\$ <u>1,990</u>				
<u>Ken Bogard</u>	<u>Administrator</u>	<u>0</u>	<u>81,944</u>	<u>Unemployment Compensation Insurance</u>	<u>68,290</u>	<u>Advertising: Employee Recruitment</u>	<u>1,306</u>				
				<u>FICA Taxes</u>	<u>144,520</u>	<u>Health Care Worker Background Check</u>					
				<u>Employee Health Insurance</u>	<u>(9,434)</u>	(Indicate # of checks performed )					
				<u>Employee Meals</u>		<u>Patient Background Checks</u>	<u>94</u>				
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>Miscellaneous Dues &amp; Subscriptions</u>	<u>120</u>				
				<u>Employee Relations</u>	<u>4,762</u>	<u>Home Office Allocation</u>	<u>1,643</u>				
				<u>Employee Retirement</u>	<u>485</u>	<u>Miscellaneous Licenses &amp; Permits</u>	<u>1,079</u>				
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ <u>113,904</u></b>				<u>LTC Solutions License</u>	<u>1,600</u>			
<b>(List each licensed administrator separately.)</b>							<u>IHCA Dues</u>	<u>2,043</u>			
<b>B. Administrative - Other</b>								<u>Less: Public Relations Expense</u>	( )		
<b>Description</b>			<b>Amount</b>				<u>Non-allowable advertising</u>	( )			
<u>Management Fees-See Page 6, Eliminated on P 3, C 7</u>			<u>\$ 142,500</u>				<u>Yellow page advertising</u>	( )			
							<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>	<b>\$ <u>10,721</u></b>			
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ <u>142,500</u></b>								
<b>(Attach a copy of any management service agreement)</b>											
<b>C. Professional Services</b>				<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>				<b>G. Schedule of Travel and Seminar**</b>			
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount			
<u>E-Health Data Solutions</u>	<u>Computer Services</u>		<u>\$ 2,351</u>				<u>Out-of-State Travel</u>	\$			
<u>McGladrey &amp; Pullen, LLC</u>	<u>Accounting Services</u>		<u>4,430</u>								
<u>AT&amp;T</u>	<u>Computer Services</u>		<u>120</u>	<u>N/A</u>			<u>In-State Travel</u>				
<u>Vasilion Architects</u>	<u>Architectural Services</u>		<u>7,545</u>								
							<u>Seminar Expense</u>				
							<u>Home Office Allocation</u>	<u>1,074</u>			
							<u>Entertainment Expense</u>	( )			
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ <u>14,446</u></b>	<b>TOTAL</b>			<b>\$</b>				
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>							<b>TOTAL (agree to Sch. V, line 24, col. 8)</b>				
							<b>\$ <u>1,074</u></b>				

\* Attach copy of IMRF notifications

\*\*See instructions.

**North Aurora Care Center**

**0047514**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		14,446

**Home Office Allocation**

Pearl & Associates	Legal	45
Addy Bush & Assoc	Legal	23
Registered Agent Solutions	Legal	4
Heyl, Royster, Voelker & Allen	Legal	101
Duane Morris	Legal	157
Ginoli & Co.	Accountants	5,147
RSM McGladrey	Accountants	277
McGladrey & Pullen	Accountants	422
Emdeon Business Services	Computer Services	110
Advanced Answers on Demand	Computer Services	2,964
Access 2 Go	Computer Services	224
Ivans	Computer Services	993
Kemper Technology	Computer Services	465
Adminastar Federal	Computer Services	58
Logmein	Computer Services	37
E-Health Data Solutions	Computer Services	290
Miscellaneous Vendors	Computer Services	32
Julie Breedlove	Computer Services	34
Amerisearch	Employment Fees	1,344

Total (agree to Schedule V, line 19, column 8)	<u><u>27,173</u></u>
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Facility Name & ID Number North Aurora Care Center# 0047514Report Period Beginning: 01/01/2007Ending: 12/31/2007**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-\$2,043
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,709 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,628  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? 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 & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit still in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees