

Facility Name & ID Number North Aurora Care Center

0047514 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	47,214	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	129	TOTALS	129	47,214	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	
8	SNF				8
9	SNF/PED				9
10	ICF	39,290	2,175		41,465
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	39,290	2,175		41,465

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.82%

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: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number North Aurora Care Center # 0047514 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	178,064	21,896	7,404	207,364		207,364	7,370	214,734		1
2	Food Purchase		193,882		193,882		193,882	128	194,010		2
3	Housekeeping	117,714	37,321		155,035		155,035	54	155,089		3
4	Laundry	41,883	6,054		47,937		47,937	3	47,940		4
5	Heat and Other Utilities			104,843	104,843		104,843	764	105,607		5
6	Maintenance	68,189	30,046	38,282	136,517		136,517	6,768	143,285		6
7	Other (specify):* Home Off. Ben. All.							2,510	2,510		7
8	TOTAL General Services	405,850	289,199	150,529	845,578		845,578	17,597	863,175		8
	B. Health Care and Programs										
9	Medical Director			11,700	11,700		11,700		11,700		9
10	Nursing and Medical Records	1,310,541	53,717	1,100	1,365,358		1,365,358	12,793	1,378,151		10
10a	Therapy		19		19		19		19		10a
11	Activities	89,128	1,576	25	90,729		90,729		90,729		11
12	Social Services	112,069	(119)		111,950		111,950	18	111,968		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,233	2,233		15
16	TOTAL Health Care and Programs	1,511,738	55,193	12,825	1,579,756		1,579,756	15,044	1,594,800		16
	C. General Administration										
17	Administrative	84,778		172,000	256,778		256,778	(110,124)	146,654		17
18	Directors Fees										18
19	Professional Services			17,588	17,588		17,588	12,283	29,871		19
20	Dues, Fees, Subscriptions & Promotions			4,446	4,446		4,446	2,095	6,541		20
21	Clerical & General Office Expenses	36,916	6,679	13,072	56,667		56,667	82,793	139,460		21
22	Employee Benefits & Payroll Taxes			239,161	239,161		239,161		239,161		22
23	Inservice Training & Education			747	747		747	467	1,214		23
24	Travel and Seminar							467	467		24
25	Other Admin. Staff Transportation			8,959	8,959		8,959	16,145	25,104		25
26	Insurance-Prop.Liab.Malpractice			23,734	23,734		23,734	345	24,079		26
27	Other (specify):* Home Off. Ben. All.							23,678	23,678		27
28	TOTAL General Administration	121,694	6,679	479,707	608,080		608,080	28,149	636,229		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,039,282	351,071	643,061	3,033,414		3,033,414	60,790	3,094,204		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:

1/1/2008

Ending:

12/31/2008

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			105,032	105,032		105,032	8,110	113,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			275,796	275,796		275,796	26,525	302,321			32
33	Real Estate Taxes			49,467	49,467		49,467	1,052	50,519			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			21,544	21,544		21,544	897	22,441			35
36	Other (specify):*											36
37	TOTAL Ownership			451,839	451,839		451,839	36,584	488,423			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			70,823	70,823		70,823		70,823			42
43	Other (specify):* Non-allowable Cost			61,847	61,847		61,847	(61,847)				43
44	TOTAL Special Cost Centers			132,670	132,670		132,670	(61,847)	70,823			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,039,282	351,071	1,227,570	3,617,923		3,617,923	35,527	3,653,450			45

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

North Aurora Care Center

ID# 0047514

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Office Supplies Revenue	\$ (344)	21	1
2				2
3				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	Total	(344)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Aurora Care Center# 0047514

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	7,370	0	0	0	0	0	0	0	0	0	7,370	1
2	Food Purchase	0	121	0	7	0	0	0	0	0	0	0	128	2
3	Housekeeping	0	54	0	0	0	0	0	0	0	0	0	54	3
4	Laundry	0	3	0	0	0	0	0	0	0	0	0	3	4
5	Heat and Other Utilities	0	764	0	0	0	0	0	0	0	0	0	764	5
6	Maintenance	0	4,504	0	2,264	0	0	0	0	0	0	0	6,768	6
7	Other (specify):*	0	1,812	0	698	0	0	0	0	0	0	0	2,510	7
8	TOTAL General Services	0	14,628	0	2,969	0	0	0	0	0	0	0	17,597	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	0	12,792	0	1	0	0	0	0	0	0	0	12,793	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	18	0	0	0	0	0	0	0	18	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	2,233	0	0	0	0	0	0	0	0	0	2,233	15
16	TOTAL Health Care and Programs	0	15,025	0	19	0	0	0	0	0	0	0	15,044	16
	C. General Administration													
17	Administrative	0	(114,625)	0	4,501	0	0	0	0	0	0	0	(110,124)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,476	0	5,807	0	0	0	0	0	0	0	12,283	19
20	Fees, Subscriptions & Promotions	0	0	1,997	98	0	0	0	0	0	0	0	2,095	20
21	Clerical & General Office Expenses	(344)	0	72,000	11,137	0	0	0	0	0	0	0	82,793	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	437	30	0	0	0	0	0	0	0	467	23
24	Travel and Seminar	0	0	438	29	0	0	0	0	0	0	0	467	24
25	Other Admin. Staff Transportation	0	0	5,669	10,476	0	0	0	0	0	0	0	16,145	25
26	Insurance-Prop.Liab.Malpractice	0	0	345	0	0	0	0	0	0	0	0	345	26
27	Other (specify):*	0	0	20,498	3,180	0	0	0	0	0	0	0	23,678	27
28	TOTAL General Administration	(344)	(108,149)	101,384	35,258	0	0	0	0	0	0	0	28,149	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(344)	(78,496)	101,384	38,246	0	0	0	0	0	0	0	60,790	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Aurora Care Center# 0047514

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	(2,308)	0	7,844	2,574	0	0	0	0	0	0	0	8,110	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	5,518	21,007	0	0	0	0	0	0	0	26,525	32
33	Real Estate Taxes	0	0	1,052	0	0	0	0	0	0	0	0	1,052	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	897	0	0	0	0	0	0	0	0	897	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,308)	0	15,311	23,581	0	36,584	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):*	(61,847)	0	0	0	0	0	0	0	0	0	0	(61,847)	43
44	TOTAL Special Cost Centers	(61,847)	0	0	0	0	0	0	0	0	0	0	(61,847)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(64,499)	(78,496)	116,695	61,827	0	35,527	45						

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	100	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%	\$ 7,370	\$ 7,370	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	121	121	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	54	54	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	764	764	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,504	4,504	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,812	1,812	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	12,792	12,792	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,233	2,233	10
11	V	17 Administrative	172,000	Petersen Health Care, Inc.	100.00%	57,375	(114,625)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,476	6,476	12
13	V							13
14	Total		\$ 172,000			\$ 93,504	\$ * (78,496)	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%	\$ 1,997	\$ 1,997
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	72,000	72,000
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	437	437
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	438	438
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	5,669	5,669
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	345	345
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	20,498	20,498
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	7,844	7,844
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,518	5,518
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,052	1,052
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0	
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	897	897
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 116,695	\$ * 116,695

* 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%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Operations, LLC	100.00%	7	7	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%	2,264	2,264	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	698	698	21	
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	1	1	22	
23	V	12 Social Service		Petersen Health Operations, LLC	100.00%	18	18	23	
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	4,501	4,501	24	
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	5,807	5,807	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	98	98	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	11,137	11,137	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%	30	30	29	
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	29	29	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	10,476	10,476	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	3,180	3,180	33	
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	2,574	2,574	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	21,007	21,007	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		\$			\$ 61,827	\$ *	61,827	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:

1/1/2008

Ending:

12/31/2008

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	1,771,299	1.72	2.87	Salary	57,375	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	\$ 57,375		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: 1/1/2008Ending: 2/31/2008

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	1,413,604	69	251,260	250,687	41,465	\$ 7,370	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	41,465	121	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	41,465	54	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	41,465	3	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	41,465	764	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	41,465	4,504	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	41,465	1,812	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	41,465	12,792	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	41,465	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	41,465	2,233	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	41,465	57,375	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	41,465	6,476	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	41,465	1,997	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	41,465	72,000	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	41,465	437	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	41,465	438	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	41,465	5,669	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	41,465	345	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	41,465	20,498	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	41,465	7,844	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	41,465	5,518	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	41,465	1,052	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	41,465	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	41,465	897	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 210,199	25

Facility Name & ID Number North Aurora Care Center# 0047514

Report Period Beginning:

1/1/2008Ending: 2/31/2008

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	419,957	23	\$	41,465	\$	1
2	2	Food	Resident Days	419,957	23	68	41,465	7	2
3	3	Housekeeping	Resident Days	419,957	23		41,465		3
4	4	Laundry	Resident Days	419,957	23		41,465		4
5	5	Utilities	Resident Days	419,957	23		41,465		5
6	6	Maintenance	Resident Days	419,957	23	22,929	41,465	2,264	6
7	7	Mgmt. Allocation of Benefits	Resident Days	419,957	23	7,067	41,465	698	7
8	10	Nursing and Medical Records	Resident Days	419,957	23	6	41,465	1	8
9	12	Social Services	Resident Days	419,957	23	187	41,465	18	9
10	17	Administrative	Resident Days	419,957	23	45,582	41,465	4,501	10
11	19	Professional Services	Resident Days	419,957	23	58,812	41,465	5,807	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	419,957	23	997	41,465	98	12
13	21	Clerical and General Office	Resident Days	419,957	23	112,798	41,465	11,137	13
14	22	Employee Benefits & Payroll	Resident Days	419,957	23		41,465		14
15	23	Inservice Training & Education	Resident Days	419,957	23	299	41,465	30	15
16	24	Travel and Seminar	Resident Days	419,957	23	296	41,465	29	16
17	25	Other Admin. Staff Transport.	Resident Days	419,957	23	106,105	41,465	10,476	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	419,957	23		41,465		18
19	27	Mgmt. Allocation of Benefits	Resident Days	419,957	23	32,211	41,465	3,180	19
20	30	Depreciation	Resident Days	419,957	23	26,070	41,465	2,574	20
21	32	Interest	Resident Days	419,957	23	212,765	41,465	21,007	21
22	33	Real Estate Taxes	Resident Days	419,957	23		41,465		22
23	34	Rent-Facility and Grounds	Resident Days	419,957	23		41,465		23
24	35	Rent-Equipment & Vehicles	Resident Days	419,957	23		41,465		24
25	TOTALS					\$ 626,192	\$ 55,582	\$ 61,827	25

Facility Name & ID Number

North Aurora Care Center

0047514

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
A. Directly Facility Related																
Long-Term																
1	Bank of America		X	Mortgage	Varies	9/30/05	\$ 4,250,000	\$ 4,174,683	12/31/13	Varies	\$ 275,796	1				
2												2				
3												3				
4							Home Office Allocation-PHC				5,518	4				
5							Home Office Allocation-PHO				21,007	5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 4,250,000	\$ 4,174,683			\$ 302,321	9				
B. Non-Facility Related*																
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related						\$	\$			\$	14				
15	TOTALS (line 9+line14)						\$ 4,250,000	\$ 4,174,683			\$ 302,321	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 (continued)

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.		\$	40,000	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.)	2007	\$	43,967	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3,967	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	45,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			1,052	
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.		\$	50,519	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	_____	8
	2004	_____	9
	2005	38,117	10
	2006	38,563	11
	2007	43,967	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>12-34-329-041</u>	<u>Long-Term Care Facility</u>	\$ <u>43,966.82</u>	\$ <u>43,966.82</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>43,966.82</u>	\$ <u>43,966.82</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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:

1/1/2008

Ending:

12/31/2008

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:

	1	2	3	4	
A. Land.	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	TOTALS	27,812		\$ 72,000	3

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	\$ 181,790
5									
6									
7									
8									
	Improvement Type**								
9									
10	Original Land Improvements	2005		15,000		15	1,000	1,000	3,500
11	Sidewalks	2006		23,280		15	1,552	1,552	3,880
12	New Wall In	2006		2,425		25	97	97	243
13	Water Line Replacement	2006		3,775		25	151	151	378
14	Water Pump Replacement	2006		3,200		15	213	213	533
15	Fence	2007		6,150		15	410	410	615
16	Fire Door	2007		1,843		15	123	123	184
17	3 Bathrooms-Construction and Demolition	2007		19,710		15	1,314	1,314	1,820
18	Coil-Water Heater	2007		4,900		15	327	327	490
19	Compressor	2007		3,295		15	220	220	330
20	Employee Breakroom (Cabinets, Counter, Sink, Mouldings)	2007		2,976		15	198	198	248
21	Sprinkler repair	2008		3,782		20	95	95	95
22	Backflow preventer	2008		6,400		25	128	128	128
23	Roof repair	2008		2,960		25	59	59	59
24	Renovations for bathrooms and tub rooms	2008		23,000		39	295	295	295
25									
26									
27									
28	Building Booked				51,981			(51,981)	
29	Building Improvement Booked				6,027			(6,027)	
30									
31									
32	2008-Home Office Allocation-Land Improvements			1,441			93	93	
33	2008-Home Office Allocation-Building Improvements			21,530			516	516	
34									
35									
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
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								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,444,167	\$ 58,008		\$ 58,731	\$ 723	\$ 194,588	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:

1/1/2008

Ending:

12/31/2008

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	\$ 309,200	\$ 46,467	\$ 44,184	\$ (2,283)	3-10	\$ 150,772	71
72	Current Year Purchases	5,849	557	418	(139)	7	418	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			9,809	9,809			74
75	TOTALS	\$ 315,049	\$ 47,024	\$ 54,411	\$ 7,387		\$ 151,190	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	N/A									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)	\$ 1,831,216	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,032	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 113,142	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 8,110	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 345,778	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 5,285 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18	Facility	2006 Ford E250	578.17	17,156	18
19					19
20					20
21	TOTAL		\$ 578.17	\$ 17,156	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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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

1/1/2008

Period End

12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	546
Dishwasher		649
Laundry Equipment		59
Copier		3,134
Home Office Allocation		897
		<u>5,285</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>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>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		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	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.

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		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2)	hrs				19		19	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	19		\$	19

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.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,146,451	1
2	Restatements (describe):		2
3			3
4			4
5	Rounding	(2)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,146,449	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	633,553	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 633,553	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,780,002	24 *

* This must agree with page 17, line 47.

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	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,251,132	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,251,132	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	344	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 344	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,251,476	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	845,578	31
32	Health Care	1,579,756	32
33	General Administration	608,080	33
	B. Capital Expense		
34	Ownership	451,839	34
	C. Ancillary Expense		
35	Special Cost Centers	61,847	35
36	Provider Participation Fee	70,823	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,617,923	40
41	Income before Income Taxes (line 30 minus line 40)**	633,553	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 633,553	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 part of 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: 1/1/2008

Ending: 12/31/2008

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	\$ 76,221	\$ 36.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,186	5,471	154,146	28.18	3
4	Licensed Practical Nurses	15,928	16,576	437,919	26.42	4
5	CNAs & Orderlies	43,171	45,723	622,678	13.62	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	30,936	14.87	9
10	Activity Assistants	4,330	4,465	48,499	10.86	10
11	Social Service Workers	7,217	7,350	112,069	15.25	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,015	17.31	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,972	15,683	142,049	9.06	15
16	Dishwashers					16
17	Maintenance Workers	5,780	5,985	68,189	11.39	17
18	Housekeepers	12,649	12,930	117,714	9.10	18
19	Laundry	4,961	5,199	41,883	8.06	19
20	Administrator	2,080	2,080	84,778	40.76	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,844	2,874	36,916	12.84	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: <u>Transportation</u>	874	874	9,693	11.09	32
33	Other(specify) <u>Care Plan Coord.</u>	679	679	19,577	28.83	33
34	TOTAL (lines 1 - 33)	126,911	132,129	\$ 2,039,282 *	\$ 15.43	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	144	\$ 7,404	1(3)	35
36	Medical Director	Monthly	11,700	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	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)	144	\$ 20,204		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

North Aurora Care Center

0047514

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		17,588

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	473
GoffWilson, P.A.	Legal	786
Ginoli & Company	Accountants	6,578
RSM McGladrey	Accountants	18
Miscellaneous Vendors	Computer Services	92
Emdeon Business Services	Computer Services	127
Advanced Answers on Demand	Computer Services	1,488
Access 2 Go	Computer Services	439
Ivans	Computer Services	1,017
Kemper Technology	Computer Services	806
VisionShare	Computer Services	86
Logmein	Computer Services	62
Comm Net Communiations	Computer Services	23
Charter Communications	Computer Services	19
Advanced System Designs	Computer Services	29
Consolidated Communications	Computer Services	17
Miscellaneous Vendors	Miscellaneous	223

Total (agree to Schedule V, line 19, column 8)	<u><u>29,871</u></u>
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North Aurora Care Center

0047514

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

<u>Name</u>	<u>Function</u>	<u>Ownership %</u>	<u>Amount</u>
Ken Bogard	Administrator	0	84,778
	Total		<u>84,778</u>

Facility Name & ID Number North Aurora Care Center# 0047514Report Period Beginning: 1/1/2008Ending: 12/31/2008**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. 3,040 -IHCA
- (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? No
- (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. \$ 11,985 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? N/A
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. \$ 70,823
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? N/A Indicate the amount. \$ N/A
- (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. \$ No
- 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? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (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 currently 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees