

Facility Name & ID Number North Aurora Care Center

0047514 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	<u>129</u>	Intermediate (ICF)	<u>129</u>	<u>47,085</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>129</u>	TOTALS	<u>129</u>	<u>47,085</u>	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	<u>37,963</u>	<u>1,793</u>		<u>39,756</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>37,963</u>	<u>1,793</u>		<u>39,756</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.43%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?

YES Date 10/1/2005 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: 12/31/2009 Fiscal Year: 12/31/2009

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

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	188,917	21,191	7,404	217,512		217,512	6,952	224,464		1
2	Food Purchase		199,124		199,124		199,124	126	199,250		2
3	Housekeeping	117,638	42,337		159,975		159,975	65	160,040		3
4	Laundry	42,371	8,598		50,969		50,969		50,969		4
5	Heat and Other Utilities			98,025	98,025		98,025	686	98,711		5
6	Maintenance	42,708	15,920	36,339	94,967		94,967	7,261	102,228		6
7	Other (specify):* Home Off. Ben. All.							1,255	1,255		7
8	TOTAL General Services	391,634	287,170	141,768	820,572		820,572	16,345	836,917		8
	B. Health Care and Programs										
9	Medical Director			10,800	10,800		10,800		10,800		9
10	Nursing and Medical Records	1,411,794	56,022	1,368	1,469,184		1,469,184	4,139	1,473,323		10
10a	Therapy		13		13		13		13		10a
11	Activities	93,819	941		94,760		94,760		94,760		11
12	Social Services	113,232	14		113,246		113,246		113,246		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							518	518		15
16	TOTAL Health Care and Programs	1,618,845	56,990	12,168	1,688,003		1,688,003	4,657	1,692,660		16
	C. General Administration										
17	Administrative	20,750		223,000	243,750		243,750	(154,730)	89,020		17
18	Directors Fees										18
19	Professional Services			32,435	32,435		32,435	12,462	44,897		19
20	Dues, Fees, Subscriptions & Promotions			8,004	8,004		8,004	5,284	13,288		20
21	Clerical & General Office Expenses	47,317	8,427	17,021	72,765		72,765	76,817	149,582		21
22	Employee Benefits & Payroll Taxes			242,034	242,034		242,034		242,034		22
23	Inservice Training & Education			708	708		708	724	1,432		23
24	Travel and Seminar							223	223		24
25	Other Admin. Staff Transportation			7,450	7,450		7,450	4,193	11,643		25
26	Insurance-Prop.Liab.Malpractice			43,511	43,511		43,511	1,449	44,960		26
27	Other (specify):* Home Off. Ben. All.							27,398	27,398		27
28	TOTAL General Administration	68,067	8,427	574,163	650,657		650,657	(26,180)	624,477		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,078,546	352,587	728,099	3,159,232		3,159,232	(5,178)	3,154,054		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:

1/1/2009

Ending:

12/31/2009

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			106,936	106,936		106,936	12,775	119,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			211,612	211,612		211,612	52,853	264,465			32
33	Real Estate Taxes			52,675	52,675		52,675	880	53,555			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,354	17,354		17,354	842	18,196			35
36	Other (specify):*											36
37	TOTAL Ownership			388,577	388,577		388,577	67,350	455,927			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		80		80		80		80			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		437	3,815	4,252		4,252	(4,252)				43
44	TOTAL Special Cost Centers		517	74,443	74,960		74,960	(4,252)	70,708			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,078,546	353,104	1,191,119	3,622,769		3,622,769	57,920	3,680,689			45

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

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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	(30)	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	4,622	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	(42)	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	(62)	43		18
19	Entertainment				19
20	Contributions	(524)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,369)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(671)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (161)		\$	30

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)	58,081	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 58,081		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 57,920		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

BHF USE ONLY						
48		49		50		51
						52

North Aurora Care Center

ID# 0047514

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Offset Miscellaneous Office Supplies Revenue	\$ (174)	21	1
2	Offset Nursing Office Supplies Revenue	(69)	10	2
3	Resident Flowers	(75)	43	3
4	Disallowed Special Events	(95)	43	4
5	Disallowed Chamber of Commerce Dues	(258)	20	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		(671)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Aurora Care Center# 0047514

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	6,952	0	0	0	0	0	0	0	0	0	6,952	1
2	Food Purchase	(30)	156	0	0	0	0	0	0	0	0	0	126	2
3	Housekeeping	0	65	0	0	0	0	0	0	0	0	0	65	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	686	0	0	0	0	0	0	0	0	0	686	5
6	Maintenance	0	3,367	0	3,894	0	0	0	0	0	0	0	7,261	6
7	Other (specify):*	0	1,255	0	0	0	0	0	0	0	0	0	1,255	7
8	TOTAL General Services	(30)	12,481	0	3,894	0	16,345	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	(69)	4,208	0	0	0	0	0	0	0	0	0	4,139	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	518	0	0	0	0	0	0	0	0	0	518	15
16	TOTAL Health Care and Programs	(69)	4,726	0	0	0	0	0	0	0	0	0	4,657	16
	C. General Administration													
17	Administrative	0	(154,730)	0	0	0	0	0	0	0	0	0	(154,730)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,748	0	2,714	0	0	0	0	0	0	0	12,462	19
20	Fees, Subscriptions & Promotions	(258)	0	2,717	2,825	0	0	0	0	0	0	0	5,284	20
21	Clerical & General Office Expenses	(174)	0	70,893	6,098	0	0	0	0	0	0	0	76,817	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	724	0	0	0	0	0	0	0	0	724	23
24	Travel and Seminar	0	0	223	0	0	0	0	0	0	0	0	223	24
25	Other Admin. Staff Transportation	0	0	3,494	699	0	0	0	0	0	0	0	4,193	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,449	0	0	0	0	0	0	0	0	1,449	26
27	Other (specify):*	0	0	19,029	8,369	0	0	0	0	0	0	0	27,398	27
28	TOTAL General Administration	(432)	(144,982)	98,529	20,705	0	(26,180)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(531)	(127,775)	98,529	24,599	0	(5,178)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Aurora Care Center# 0047514

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	4,622	0	5,730	2,423	0	0	0	0	0	0	0	12,775	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	8,813	44,040	0	0	0	0	0	0	0	52,853	32
33	Real Estate Taxes	0	0	880	0	0	0	0	0	0	0	0	880	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	842	0	0	0	0	0	0	0	0	842	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	4,622	0	16,265	46,463	0	67,350	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):*	(4,252)	0	0	0	0	0	0	0	0	0	0	(4,252)	43
44	TOTAL Special Cost Centers	(4,252)	0	0	0	0	0	0	0	0	0	0	(4,252)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(161)	(127,775)	114,794	71,062	0	0	0	0	0	0	0	57,920	45

Facility Name & ID Number

North Aurora Care Center

0047514

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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%	\$ 6,952	\$ 6,952	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	156	156	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	65	65	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	686	686	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,367	3,367	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,255	1,255	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,208	4,208	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%	518	518	10
11	V	17 Administrative	223,000	Petersen Health Care, Inc.	100.00%	68,270	(154,730)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	9,748	9,748	12
13	V							13
14	Total		\$ 223,000			\$ 95,225	\$ * (127,775)	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 <u>Dues, Fees, Subs and Promotions</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 2,717	\$	2,717	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care, Inc.</u>	100.00%	70,893		70,893	16
17	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Care, Inc.</u>	100.00%	724		724	17
18	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care, Inc.</u>	100.00%	223		223	18
19	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	3,494		3,494	19
20	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,449		1,449	20
21	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	19,029		19,029	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care, Inc.</u>	100.00%	5,730		5,730	22
23	V	32 <u>Interest</u>		<u>Petersen Health Care, Inc.</u>	100.00%	8,813		8,813	23
24	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care, Inc.</u>	100.00%	880		880	24
25	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0			25
26	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Care, Inc.</u>	100.00%	842		842	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 114,794	\$ *	114,794	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%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	3,894	3,894	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	2,714	2,714	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	2,825	2,825	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	6,098	6,098	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	699	699	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%	8,369	8,369	33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	2,423	2,423	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	44,040	44,040	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		\$			\$ 71,062	\$ *	71,062 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: 1/1/2009 Ending: 12/31/2009

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	154,593	1.55	2.58	Salary	\$ 4,520	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	\$ 4,520		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:

1/1/2009

Ending: 2/31/2009

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	1,493,044	75	\$ 261,102	\$ 259,584	39,756	\$ 6,952	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	39,756	156	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	39,756	65	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	39,756	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	39,756	686	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	39,756	3,367	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	39,756	1,255	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	39,756	4,208	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	39,756	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	39,756	518	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	39,756	68,270	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	39,756	9,748	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	39,756	2,717	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	39,756	70,893	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	39,756	724	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	39,756	223	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	39,756	3,494	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	39,756	1,449	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	39,756	19,029	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	39,756	5,730	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	39,756	8,813	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	39,756	880	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	39,756	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	39,756	842	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 210,019	25

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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	399,145	21		39,756		1
2	2	Food	Resident Days	399,145	21		39,756		2
3	3	Housekeeping	Resident Days	399,145	21		39,756		3
4	4	Laundry	Resident Days	399,145	21		39,756		4
5	5	Utilities	Resident Days	399,145	21		39,756		5
6	6	Maintenance	Resident Days	399,145	21	39,101	39,756	3,894	6
7	7	Mgmt. Allocation of Benefits	Resident Days	399,145	21		39,756		7
8	10	Nursing and Medical Records	Resident Days	399,145	21		39,756		8
9	12	Social Services	Resident Days	399,145	21		39,756		9
10	17	Administrative	Resident Days	399,145	21		39,756		10
11	19	Professional Services	Resident Days	399,145	21	27,247	39,756	2,714	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	399,145	21	28,366	39,756	2,825	12
13	21	Clerical and General Office	Resident Days	399,145	21	61,225	39,756	6,098	13
14	22	Employee Benefits & Payroll	Resident Days	399,145	21		39,756		14
15	23	Inservice Training & Education	Resident Days	399,145	21		39,756		15
16	24	Travel and Seminar	Resident Days	399,145	21		39,756		16
17	25	Other Admin. Staff Transport.	Resident Days	399,145	21	7,018	39,756	699	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	399,145	21		39,756		18
19	27	Mgmt. Allocation of Benefits	Resident Days	399,145	21	84,024	39,756	8,369	19
20	30	Depreciation	Resident Days	399,145	21	24,325	39,756	2,423	20
21	32	Interest	Resident Days	399,145	21	442,158	39,756	44,040	21
22	33	Real Estate Taxes	Resident Days	399,145	21		39,756		22
23	34	Rent-Facility and Grounds	Resident Days	399,145	21		39,756		23
24	35	Rent-Equipment & Vehicles	Resident Days	399,145	21		39,756		24
25	TOTALS					\$ 713,464	\$	\$ 71,062	25

Facility Name & ID Number

North Aurora Care Center

0047514

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	11						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
	A. Directly Facility Related																	
	Long-Term																	
1	Bank of America		X	Mortgage	Varies	9/30/05	\$ 4,250,000	\$ 4,125,253	12/31/13	Varies	\$ 211,612	1						
2												2						
3												3						
4							Home Office Allocation-PHC				8,813	4						
5							Home Office Allocation-PHO				44,040	5						
	Working Capital																	
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 4,250,000	\$ 4,125,253			\$ 264,465	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	\$ 4,125,253			\$ 264,465	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

1. Real Estate Tax accrual used on 2008 report.		\$	45,500	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.)	2008	\$	48,375	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,875	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	49,800	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. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	880	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	53,555	7

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2004		8
	2005	38,117	9
	2006	38,563	10
	2007	43,967	11
	2008	48,375	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>48,375.02</u>	\$ <u>48,375.02</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 and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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>	1
2					2
3	TOTALS	<u>27,812</u>		<u>\$ 72,000</u>	3

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	\$ 233,730	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Original Land Improvements	2005		15,000		15	1,000	1,000	4,500	9
10	Sidewalks	2006		23,280		15	1,552	1,552	5,432	10
11	New Wall In	2006		2,425		25	97	97	340	11
12	Water Line Replacement	2006		3,775		25	151	151	529	12
13	Water Pump Replacement	2006		3,200		15	213	213	746	13
14	Fence	2007		6,150		15	410	410	1,025	14
15	Fire Door	2007		1,843		15	123	123	307	15
16	3 Bathrooms-Construction and Demolition	2007		19,710		15	1,314	1,314	3,134	16
17	Coil-Water Heater	2007		4,900		15	327	327	817	17
18	Compressor	2007		3,295		15	220	220	550	18
19	Employee Breakroom (Cabinets, Counter, Sink, Mouldings)	2007		2,976		15	198	198	446	19
20	Sprinkler repair	2008		3,782		20	190	190	285	20
21	Backflow preventer	2008		6,400		25	256	256	384	21
22	Roof repair	2008		2,960		25	118	118	177	22
23	Renovations for bathrooms and tub rooms	2008		23,000		39	590	590	885	23
24	Fence	2009		8,270		15	276	276	276	24
25	Pipe Valve Repair	2009		4,406		7	315	315	315	25
26	Video Camera System	2009		7,357		5	736	736	736	26
27	Sprinkler System Installation	2009		25,768		20	644	644	644	27
28	Security Lock System	2009		12,131		5	1,213	1,213	1,213	28
29	Sprinkler Installation in Lower Level	2009		12,272		20	307	307	307	29
30	Parking Lot	2009		162,664		25	3,253	3,253	3,253	30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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			3,642			(3,642)		45
46			51,981			(51,981)		46
47			6,308			(6,308)		47
48								48
49								49
50		1,308			82	82		50
51		19,544			469	469		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		\$ 1,674,916	\$ 61,931		\$ 65,994	\$ 4,063	\$ 260,031	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:

1/1/2009

Ending:

12/31/2009

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	\$ 315,049	\$ 43,879	\$ 45,020	\$ 1,141	3-10 yrs.	\$ 196,210	71
72	Current Year Purchases	10,878	1,126	544	(582)	10 yrs.	544	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			8,153	8,153			74
75	TOTALS	\$ 325,927	\$ 45,005	\$ 53,717	\$ 8,712		\$ 196,754	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)	\$ 2,072,843	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,936	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 119,711	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,775	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 456,785	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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

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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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: \$ 11,333 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford E250 Van	\$ 571.88	\$ 6,863	17
18					18
19					19
20					20
21	TOTAL		\$ 571.88	\$ 6,863	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

North Aurora Care Center

0047514

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 5,712
Dishwasher	708
Copier	4,071
Home Office Allocation	842
	<u>11,333</u>

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</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>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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				13		13	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				80		80	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			\$		\$	93	\$	93	14	

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning: 1/1/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 4,683,486	\$ 4,683,486	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	595,953	595,953	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	65,416	65,416	6
7	Other Prepaid Expenses	16,424	16,424	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Other prepaid expenses</u>	40,000	40,000	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,401,279	\$ 5,401,279	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	287,364	72,000	13
14	Buildings, at Historical Cost	1,298,500	1,318,044	14
15	Leasehold Improvements, at Historical Cost	134,201	356,872	15
16	Equipment, at Historical Cost	324,949	325,927	16
17	Accumulated Depreciation (book methods)	(431,795)	(456,785)	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): _____			22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,613,219	\$ 1,616,058	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,014,498	\$ 7,017,337	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 434,719	\$ 434,719	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	41,268	41,268	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,317	2,317	31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,800	49,800	32
33	Accrued Interest Payable	18,450	18,450	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	95,729	95,729	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 642,283	\$ 642,283	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,125,253	4,125,253	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,125,253	\$ 4,125,253	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,767,536	\$ 4,767,536	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,246,962	\$ 2,249,801	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,014,498	\$ 7,017,337	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,780,002	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(18,525)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,761,477	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	485,485	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)	\$ 485,485	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)	\$ 2,246,962	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number North Aurora Care Center# 0047514Report Period Beginning: 1/1/2009Ending: 12/31/2009

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	\$ 4,107,981	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,107,981	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	30	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)	\$ 30	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	Miscellaneous Revenue	243	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 243	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,108,254	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	820,572	31
32	Health Care	1,688,003	32
33	General Administration	650,657	33
B. Capital Expense			
34	Ownership	388,577	34
C. Ancillary Expense			
35	Special Cost Centers	4,332	35
36	Provider Participation Fee	70,628	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,622,769	40
41	Income before Income Taxes (line 30 minus line 40)**	485,485	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 485,485	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: 1/1/2009

Ending: 12/31/2009

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	\$ 79,552	\$ 38.25	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,623	3,721	102,873	27.65	3
4	Licensed Practical Nurses	17,740	18,599	488,624	26.27	4
5	CNAs & Orderlies	47,350	50,006	679,473	13.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	32,506	15.63	9
10	Activity Assistants	3,136	3,228	34,018	10.54	10
11	Social Service Workers	6955	7,066	113,232	16.02	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	36,935	17.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,436	15,827	151,982	9.60	15
16	Dishwashers					16
17	Maintenance Workers	3,622	3,855	42,708	11.08	17
18	Housekeepers	12,909	13,288	117,638	8.85	18
19	Laundry	5,123	5,330	42,371	7.95	19
20	Administrator	2,080	2,080	84,500	40.63	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,550	3,632	47,317	13.03	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>	2,456	2,501	27,295	10.91	32
33	Other(specify) <u>Care Plan Coord.</u>	2,109	2,109	61,272	29.05	33
34	TOTAL (lines 1 - 33)	132,329	137,482	\$ 2,142,296 *	\$ 15.58	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	Monthly	\$ 6,787	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	1,200	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)		\$ 18,787		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	5	\$ 168	10(3)	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	5	\$ 168		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	
Ken Bogard	Administrator	0	\$ 84,500	Workers' Compensation Insurance	\$ 60,699	IDPH License Fee	\$ 995	
				Unemployment Compensation Insurance	32,809	Advertising: Employee Recruitment	716	
				FICA Taxes	155,243	Health Care Worker Background Check		
				Employee Health Insurance	(9,069)	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	345 3,450	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	495	
				Employee Relations	1,987	Miscellaneous Dues & Subscriptions	258	
				Employee Retirement	365	IHCA Dues	1,500	
						Home Office Allocation	5,542	
						Kane County Health Department	590	
						Less: Public Relations Expense	(258)	
						Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						TOTAL (agree to Sch. V, line 20, col. 8)		
					\$ 242,034			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description				Description		Description		
Amount				Line #		Amount		
Management Fees-See Page 6, Eliminated on P 3, C 7				N/A		Out-of-State Travel		
\$ 223,000						\$		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL		In-State Travel		
\$ 223,000								
C. Professional Services						Seminar Expense		
Vendor/Payee	Type		Amount			Home Office Allocation		
E-Health Data Solutions	Computer Services		\$ 3,135			223		
AT&T	Computer Services		480			Entertainment Expense		
LTC Solutions	Computer Services		1,700			()		
SimpleLTC, Inc.	Computer Services		81			TOTAL (agree to Sch. V, line 24, col. 8)		
Dommermuth, Brestal, Cobine & W	Legal Services		13,300			\$ 223		
Village of North Aurora	Legal Services		10,200					
Clifton Gunderson LLP	Accounting Services		3,000					
Heyl, Royster, Voelker, Allen	Legal Services		539					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL				
\$ 32,435				\$				

* Attach copy of IMRF notifications

**See instructions.

North Aurora Care Center

0047514

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		32,435

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	(30)
GoffWilson, P.A.	Legal	88
Jackson Lewis	Legal	695
Peter Gartelos	Legal	66
Misc.	Legal	59
Ginoli & Company	Accountants	4,205
Miscellaneous Vendors	Computer Services	65
Emdeon Business Services	Computer Services	29
Advanced Answers on Demand	Computer Services	3,745
Access 2 Go	Computer Services	360
Ivans	Computer Services	195
Kemper Technology	Computer Services	1,018
VisionShare	Computer Services	317
MediFax	Computer Services	129
LogmIn	Computer Services	56
Charter Communications	Computer Services	3
Simple LTC	Computer Services	864
Miscellaneous Vendors	Miscellaneous	598
Total (agree to Schedule V, line 19, column 8)		<u>44,897</u>

North Aurora Care Center

0047514

Period Beginning

1/1/2009

Period End

12/31/2009

Schedule 21B**XIX. SUPPORT SCHEDULE****Legal Fees****Facility**

Vendor/Payee	Invoice Total	Allocation %	Total
Dommermuth, Brestal, Cobine & West	1,475.00	100%	1,475
Heyl, Royster, Voelker, and Allen	262.60	100%	263
Heyl, Royster, Voelker, and Allen	92.00	100%	92
Heyl, Royster, Voelker, and Allen	184.00	100%	184
Dommermuth, Brestal, Cobine & West	1,975.00	100%	1,975
Dommermuth, Brestal, Cobine & West	2,225.00	100%	2,225
Dommermuth, Brestal, Cobine & West	375.00	100%	375
Dommermuth, Brestal, Cobine & West	2,775.00	100%	2,775
Village of North Aurora	573.04	100%	573
Dommermuth, Brestal, Cobine & West	625.00	100%	625
Dommermuth, Brestal, Cobine & West	3,525.00	100%	3,525
Dommermuth, Brestal, Cobine & West	50.00	100%	50
Village of North Aurora	9,341.92	100%	9,342
Village of North Aurora	285.65	100%	286
Dommermuth, Brestal, Cobine & West	275.00	100%	275

Home Office Allocation

Heyl, Royster, Voelker, and Allen	2,414.77	2.57%	62
GoffWilson	3,425.00	2.57%	88
Jackson Lewis	27,043.20	2.57%	695
Peter Gartelos	2,612.50	2.57%	66
Miscellaneous Vendors	2,327.62	2.57%	59

Management Company Allocation

Heyl, Royster, Voelker, and Allen	(927.00)	9.93%	(92)
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Total Legal Fees

24,917

Facility Name & ID Number North Aurora Care Center

0047514

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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. 1,500 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? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,235 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. \$ 70,628
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. \$ 30
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (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.