

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0056077</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>North Aurora Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>310 Banbury Road</u> <u>North Aurora</u> <u>60542</u>																																																	
Number City Zip Code																																																	
County: <u>Kane</u>																																																	
Telephone Number: <u>(630) 892-7627</u> Fax # <u>(630) 692-7925</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Type or Print Name) <u>Mark Petersen</u></td><td></td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Title) <u>Chief Executive Officer</u></td><td></td></tr><tr><td>(Signed) _____</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td><td></td></tr><tr><td>(Firm Name & Address) _____</td><td></td></tr><tr><td colspan="2"></td><td>(Telephone) <u>()</u></td><td>Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	(Type or Print Name) <u>Mark Petersen</u>		Paid Preparer	(Title) <u>Chief Executive Officer</u>		(Signed) _____	(Date) _____	(Print Name and Title) _____		(Firm Name & Address) _____				(Telephone) <u>()</u>	Fax # <u>()</u>																												
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	(Print Name and Title) _____																																																
	(Firm Name & Address) _____																																																
		(Telephone) <u>()</u>	Fax # <u>()</u>																																														
Date of Initial License for Current Owners: <u>10/1/2005</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☐</td><td>VOLUNTARY, NON-PROFIT</td><td>☒</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☐</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code _____</td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☒</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>		☐	VOLUNTARY, NON-PROFIT	☒	PROPRIETARY	☐	GOVERNMENTAL	☐	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code _____		☐	Corporation	☐	Other _____			☒	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other	_____	
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		☐	Trust	_____																																													
		☐	Other	_____																																													
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																																															
Name: <u>Mike Kocher</u> Telephone Number: <u>(309) 689-5850</u> Email Address: _____																																																	

Facility Name & ID Number North Aurora Care Center

0056077 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

1	2	3	4	5	
Level of Care	Patient Days by Level of Care and Primary Source of Payment				
	Medicaid Recipient	Private Pay	Other	Total	
8 SNF					8
9 SNF/PED					9
10 ICF	35,018	398		35,416	10
11 ICF/DD					11
12 SC					12
13 DD 16 OR LESS					13
14 TOTALS	35,018	398		35,416	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.22%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 ☐

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 _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number North Aurora Care Center # 0056077 Report Period Beginning: 1/1/2020 Ending: 12/31/2020
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	197,471	17,366		214,837		214,837	9,430	224,267			1
2	Food Purchase		226,595		226,595		226,595	(1,134)	225,461			2
3	Housekeeping	133,687	41,253		174,940		174,940	182	175,122			3
4	Laundry	59,595	14,222		73,817		73,817		73,817			4
5	Heat and Other Utilities			76,855	76,855		76,855	644	77,499			5
6	Maintenance	62,222	6,687	22,169	91,078		91,078	5,663	96,741			6
7	Other (specify):*											7
8	TOTAL General Services	452,975	306,123	99,024	858,122		858,122	14,785	872,907			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,440,285	101,996	233,404	1,775,685		1,775,685	13,417	1,789,102			10
10a	Therapy											10a
11	Activities	114,839	440		115,279		115,279		115,279			11
12	Social Services	188,601	5		188,606		188,606		188,606			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,743,725	102,441	245,404	2,091,570		2,091,570	13,417	2,104,987			16
	C. General Administration											
17	Administrative	87,000		249,800	336,800		336,800	(197,356)	139,444			17
18	Directors Fees											18
19	Professional Services			6,283	6,283		6,283	235,000	241,283			19
20	Dues, Fees, Subscriptions & Promotions			2,884	2,884		2,884	4,828	7,712			20
21	Clerical & General Office Expenses	51,575	3,021	19,256	73,852		73,852	58,462	132,314			21
22	Employee Benefits & Payroll Taxes			248,137	248,137		248,137	38,166	286,303			22
23	Inservice Training & Education							97	97			23
24	Travel and Seminar							30	30			24
25	Other Admin. Staff Transportation			4,431	4,431		4,431	6,756	11,187			25
26	Insurance-Prop.Liab.Malpractice			50,275	50,275		50,275	14,252	64,527			26
27	Other (specify):*											27
28	TOTAL General Administration	138,575	3,021	581,066	722,662		722,662	160,235	882,897			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,335,275	411,585	925,494	3,672,354		3,672,354	188,437	3,860,791			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			8,216	8,216		8,216	101,826	110,042			30
31	Amortization of Pre-Op. & Org.							269,986	269,986			31
32	Interest			1,064	1,064		1,064	615,845	616,909			32
33	Real Estate Taxes			54,399	54,399		54,399	28,343	82,742			33
34	Rent-Facility & Grounds			911,230	911,230		911,230	(911,230)				34
35	Rent-Equipment & Vehicles			23,666	23,666		23,666	18,961	42,627			35
36	Other (specify):*											36
37	TOTAL Ownership			998,575	998,575		998,575	123,731	1,122,306			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			241,546	241,546		241,546		241,546			42
43	Other (specify):*			112,420	112,420		112,420	(112,420)				43
44	TOTAL Special Cost Centers			353,966	353,966		353,966	(112,420)	241,546			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,335,275	411,585	2,278,035	5,024,895		5,024,895	199,748	5,224,643			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,134)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,994)	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	(654)	30		9
10	Interest and Other Investment Income	(421)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(85)	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	(36,028)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,050)	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	(369)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (114,735)		\$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	314,483	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 314,483		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 199,748		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Miscellaneous Income - Office Supplies	(9)	21	1
2	Offset Miscellaneous Income - Nursing Supplies	(97)	10	2
3	Special Events	11	43	3
4	Labs-Part A	(274)	43	4
5				5
6				6
7				7
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(369)		49

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

[illegible]

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 Management, Inc.	100.00%	\$ 9,430	\$ 9,430	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	182	182	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	644	644	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	5,663	5,663	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	8,836	8,836	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	249,800	Petersen Health Care Management, Inc.	100.00%	52,444	(197,356)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	30,978	30,978	12
13	V								13
14	Total			\$ 249,800			\$ 108,177	\$ * (141,623)	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 & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,828	\$ 4,828	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	58,471	58,471	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	16,051	16,051	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	97	97	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	30	30	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	6,756	6,756	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,030	1,030	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	9,546	9,546	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	465	465	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	371	371	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	3,424	3,424	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			\$			\$ 101,069	\$ * 101,069	39

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

Facility Name & ID Number North Aurora Care Center# 0056077Report Period Beginning: 1/1/2020Ending: 12/31/2020

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%	0	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0	21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	4,678	4,678 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%	204,022	204,022 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	0	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	0	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	22,115	22,115 28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0	29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0	30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0	31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0	32
33	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	0	33
34	V	31 Amortization		Petersen Health Operations, LLC	100.00%	0	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	15,756	15,756 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%	15,537	15,537 38
39	Total		\$			\$ 262,108	\$ * 262,108 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	6	Maintenance	\$	North Aurora Land, LLC	100.00%	\$	\$	15
16	V	19	Professional Services	\$	North Aurora Land, LLC	100.00%			16
17	V	21	Equipment		North Aurora Land, LLC	100.00%			17
18	V	26	Insurance-Property		North Aurora Land, LLC	100.00%	9,027	9,027	18
19	V	26	Insurance-Mortgage Insurance		North Aurora Land, LLC	100.00%	4,195	4,195	19
20	V	30	Depreciation		North Aurora Land, LLC	100.00%	92,934	92,934	20
21	V	31	Amortization		North Aurora Land, LLC	100.00%	269,986	269,986	21
22	V	32	Interest	429	North Aurora Land, LLC	100.00%	600,474	600,045	22
23	V	33	Real Estate Taxes		North Aurora Land, LLC	100.00%	27,972	27,972	23
24	V	34	Rent-Income and Grounds	911,230	North Aurora Land, LLC	100.00%		(911,230)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 911,659			\$ 1,004,588	\$ * 92,929	39

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

Facility Name & ID Number

North Aurora Care Center

0056077

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

North Aurora Care Center

0056077

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

North Aurora Care Center

0056077

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

North Aurora Care Center

0056077

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6			Betty's Garden	Kewanee				6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number North Aurora Care Center # 0056077 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number North Aurora Care Center# 0056077

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 ☐

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	35,416	\$ 9,430	1
2	2	Food	Resident Days	1,282,791	75	0	0	35,416	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	35,416	182	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	35,416	644	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	35,416	5,663	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	35,416	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	35,416	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	35,416	8,836	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	35,416	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	35,416	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	35,416	52,444	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	35,416	30,978	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	35,416	4,828	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	35,416	58,471	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	35,416	16,051	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	35,416	97	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	35,416	30	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	35,416	6,756	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	35,416	1,030	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	35,416	9,546	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	35,416	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	35,416	465	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	35,416	371	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	35,416	3,424	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 209,246	25

Facility Name & ID Number North Aurora Care Center# 0056077

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 ☐

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

Name of Related Organization

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

1	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	9	\$	\$	35,416	\$	1
2	2	Food	Resident Days	9			35,416		2
3	3	Housekeeping	Resident Days	9			35,416		3
4	4	Laundry	Resident Days	9			35,416		4
5	5	Utilities	Resident Days	9			35,416		5
6	6	Maintenance	Resident Days	9			35,416		6
7	7	Mgmt. Allocation of Benefits	Resident Days	9			35,416		7
8	10	Nursing and Medical Records	Resident Days	9	21,660		35,416	4,678	8
9	15	Mgmt. Allocation of Benefits	Resident Days	9			35,416		9
10	17	Administrative	Resident Days	9			35,416		10
11	19	Professional Services	Resident Days	9	944,677		35,416	204,022	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	9			35,416		12
13	21	Clerical and General Office	Resident Days	9			35,416		13
14	22	Employee Benefits & Payroll	Resident Days	9	102,400		35,416	22,115	14
15	23	Inservice Training & Education	Resident Days	9			35,416		15
16	24	Travel and Seminar	Resident Days	9			35,416		16
17	25	Other Admin. Staff Transport.	Resident Days	9			35,416		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	9			35,416		18
19	30	Depreciation	Resident Days	9			35,416		19
20	31	Amortization	Resident Days	9			35,416		20
21	32	Interest	Resident Days	9	72,956		35,416	15,756	21
22	33	Real Estate Taxes	Resident Days	9			35,416		22
23	34	Rent-Facility and Grounds	Resident Days	9			35,416		23
24	35	Rent-Equipment & Vehicles	Resident Days	9	71,940		35,416	15,537	24
25	TOTALS				\$ 1,213,633	\$		\$ 262,108	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Capital Finance Group		X	Mortgage	Varies	9/15/14	\$ 3,142,700	\$ Paid			\$ 16,746	1
2	Southern Bus and Mobility		X	Auto Loan	\$606.19	12/1/18	13,471	Paid			449	2
3	Sector		X	Mortgage	Varies	4/1/20	6,098,295	6,098,295	3/31/23	Varies	583,728	3
4	Dodge		X	Auto Loan	Varies	6/29/20	39,027	36,615	6/28/25	Varies	615	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$606.19		\$ 9,293,493	\$ 6,134,910			\$ 601,538	9
	B. Non-Facility Related*											
10								Interest Income Offset			(850)	10
11								Home Office Allocation-PHCM			465	11
12								Home Office Allocation-PHO			15,756	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 15,371	14
15	TOTALS (line 9+line14)						\$ 9,293,493	\$ 6,134,910			\$ 616,909	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 4,195 Line # 26

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	83,912	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.)			\$	81,915	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(1,997)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	84,368	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		371	
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.			\$	82,742	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2015	84,756	8		
	2016	81,132	9		
	2017	81,107	10		
	2018	81,471	11		
	2019	81,915	12		
Accrual based on prior year tax bill.					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	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:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 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.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Aurora Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0047514

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 12-34-329-052	Long-Term Care Facility	\$ 81,772.74	\$ 81,772.74
2. 12-34-331-005	Lot	\$ 141.92	\$ 141.92
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 81,914.66	\$ 81,914.66

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

A. Square Feet: 27,812

B. General Construction Type: ExteriorMasonryFrameBrickNumber of Stories1

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: 305,360

2. Number of Years Over Which it is Being Amortized: 3

3. Current Period Amortization: 269,986

4. Dates Incurred: 2020

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	Facility	27,812	2005	\$ 72,000	1
2					2
3	TOTALS	27,812		\$ 72,000	3

Facility Name & ID Number North Aurora Care Center

0056077

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	129		2005	1972	\$ 1,313,500	\$	25	\$ 52,540	\$ 52,540	\$ 817,770	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Original Land Improvements			2005	15,000		15	500	500	15,000	9
10	Sidewalks			2006	23,280		15	1,552	1,552	22,504	10
11	Water Line Replacement			2006	3,775		25	151	151	2,190	11
12	Water Pump Replacement			2006	3,200		15	213	213	3,089	12
13	Fence			2007	6,150		15	410	410	5,535	13
14	Coil-Water Heater			2007	4,900		15	327	327	4,414	14
15	Compressor			2007	3,295		15	220	220	3,077	15
16	Employee Breakroom (Cabinets, Counter, Sink, Mouldings)			2007	2,976		15	198	198	2,624	16
17	Sprinkler repair			2008	3,782		20	190	190	2,375	17
18	Backflow preventer			2008	6,400		25	256	256	3,200	18
19	Renovations for bathrooms and tub rooms			2008	23,000		39	590	590	7,375	19
20	Fence			2009	8,270		15	552	552	6,348	20
21	Pipe Valve Repair			2009	4,406		7			4,406	21
22	Video Camera System			2009	7,357		5			7,357	22
23	Sprinkler System Installation			2009	25,768		20	1,288	1,288	14,812	23
24	Security Lock System			2009	12,131		5			12,131	24
25	Sprinkler Installation in Lower Level			2009	12,272		20	614	614	7,061	25
26	Fence			2010	3,663		15	244	244	2,562	26
27	Sprinkler System Repair			2010	8,354		15	556	556	5,838	27
28	A/C Unit			2010	2,625		15	176	176	1,848	28
29	Parking Lot			2010	183,686		25	7,415	7,415	84,364	29
30	Sprinkler System Repair			2011	5,987		7			5,987	30
31	Water Main Repair			2012	\$ 3,300	\$	7	\$		3,300	31
32	Boiler			2012	7,666		15	512	512	4,352	32
33	Fire Alarm Installation			2012	5,363		7			5,363	33
34	Water Main Repair			2012	3,933		7	280	280	3,933	34
35	Gutter and Soffit Replacement			2013	34,150		25	1,366	1,366	8,879	35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number North Aurora Care Center

0056077

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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 Air Conditioner	2014	2,851		15	190	\$ 190	\$ 1,045	37
38 Roof Replacement	2014	134,525		25	5,381	5,381	29,596	38
39 Fire Sprinkler Line Repair	2015	5,242		7	750	750	3,375	39
40 Air Conditioner-Kitchen	2016	2,534		7	362	362	1,267	40
41 8 Steel Doors and Window Frames	2016	14,836		7	2,120	2,120	7,420	41
42 Water Heater	2016	4,554		7	650	650	2,275	42
43 Water Line Repair	2017	3,843		7	550	550	1,375	43
44 HVAC System	2017	3,200		7	458	458	1,145	44
45 Boiler Repair	2018	3,607		7	516	516	774	45
46 Water Pipe Repair	2020	5,334		7	381	381	381	46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57 Land Improvements Booked			10,923			(10,923)		57
58 Building Booked			51,981			(51,981)		58
59 Building Improvement Booked			21,128			(21,128)		59
60								60
61 2020-Home Office Allocation-Building Improvements		17,907			430	430		61
62 2020-Home Office Allocation-Land Improvements		1,796			114	114		62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 1,938,418	\$ 84,032		\$ 82,052	\$ (1,980)	\$ 1,116,347	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$98,472	\$10,521	\$12,391	\$1,870	5-10 yrs.	\$64,728	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	324,949					324,949	73
74	Home Office Allocation			9,002	9,002			74
75	TOTALS	\$423,421	\$10,521	\$21,393	\$10,872		\$389,677	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2006 Ford E-350	2012	\$5,266	\$	\$	\$		\$5,266	76
77	Facility	2017 Dodge Grand Caravan	2018	13,471	2,694	2,694		5 yrs.	6,735	77
78	Facility	2019 Dodge Grand Caravan	2020	39,027	3,903	3,903		5 yrs.	3,903	78
79										79
80	TOTALS			\$57,764	\$6,597	\$6,597	\$		\$15,904	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)	\$2,491,603	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$101,150	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$110,042	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$8,892	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,521,928	85

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

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

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			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: \$ 42,627 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					18
19					19
20					20
21	TOTAL		\$	\$	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
0056077
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	18,442
Dishwasher		643
Copier		4,581
Home Office Allocation		18,961
		<u>42,627</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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

☐

☐

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

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

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.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	N/A	hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

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

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (14,417)	\$ (14,417)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 5,866)	2,661,910	2,661,910	3
4	Supply Inventory (priced at Cost)	16,424	16,424	4
5	Short-Term Investments			5
6	Prepaid Insurance	52,346	37,451	6
7	Other Prepaid Expenses	2,655,950	2,710,822	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,372,213	\$ 5,412,190	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		72,000	13
14	Buildings, at Historical Cost		1,331,407	14
15	Leasehold Improvements, at Historical Cost	5,334	607,011	15
16	Equipment, at Historical Cost	57,764	481,185	16
17	Accumulated Depreciation (book methods)	(15,255)	(1,521,928)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		305,360	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(115,280)	20
21	Restricted Funds	79,509	542,435	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Intercompany Loans</u>	339,726	2,886,080	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 467,078	\$ 4,588,270	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,839,291	\$ 10,000,460	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 708,415	\$ 712,022	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	132,696	132,696	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	84,368	84,368	32
33	Accrued Interest Payable		73,133	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	126,688	126,688	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,052,167	\$ 1,128,907	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	36,615	36,615	39
40	Mortgage Payable		6,098,295	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	1,746,081	1,314,027	43
44	<u>Loan Payable-MCAD Adv. Payment</u>	325,000	325,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,107,696	\$ 7,773,937	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,159,863	\$ 8,902,844	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,679,428	\$ 1,097,616	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,839,291	\$ 10,000,460	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 384,561	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	1,744,634	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,129,195	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	550,233	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)	\$ 550,233	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)	\$ 2,679,428	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number North Aurora Care Center

0056077

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,449,660	1
2	Discounts and Allowances for all Levels	(1,452,910)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,996,750	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,134	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	805	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,939	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	421	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 421	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	106	28
28a	Stimulus Revenue	575,912	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 576,018	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,575,128	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	858,122	31
32	Health Care	2,091,570	32
33	General Administration	722,662	33
	B. Capital Expense		
34	Ownership	998,575	34
	C. Ancillary Expense		
35	Special Cost Centers	112,420	35
36	Provider Participation Fee	241,546	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,024,895	40
41	Income before Income Taxes (line 30 minus line 40)**	550,233	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 550,233	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 4,894,966	44
45	Private Pay - Net Inpatient Revenue	40,635	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Insurance Net Inpatient Revenue	61,149	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 4,996,750	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

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

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

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	1,695	1,719	\$ 62,215	\$ 36.19	1
2	Assistant Director of Nursing	1,167	1,167	42,282	36.23	2
3	Registered Nurses	5,499	5,750	228,764	39.79	3
4	Licensed Practical Nurses	15,444	16,435	510,424	31.06	4
5	CNAs & Orderlies	25,243	26,818	502,061	18.72	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,040	2,080	33,108	15.92	9
10	Activity Assistants	3,458	3,513	38,650	11.00	10
11	Social Service Workers	9,079	9,325	188,601	20.23	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	34,285	16.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,772	12,172	163,186	13.41	15
16	Dishwashers					16
17	Maintenance Workers	3,813	3,874	62,222	16.06	17
18	Housekeepers	9,738	10,271	133,687	13.02	18
19	Laundry	5,399	5,630	59,595	10.59	19
20	Administrator	2,056	2,080	87,000	41.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,970	3,173	51,575	16.25	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	4,505	4,732	137,620	29.08	33
34	TOTAL (lines 1 - 33)	105,958	110,819	\$ 2,335,275 *	\$ 21.07	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		\$		35
36	Medical Director	Monthly	12,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,657	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	108	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2	\$ 22,765		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	233	\$ 8,123	L10,C3	50
51	Licensed Practical Nurses	1,782	56,181	L10,C3	51
52	Certified Nurse Assistants/Aides	6,478	158,335	L10,C3	52
53	TOTAL (lines 50 - 52)	8,493	\$ 222,639		53

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Schedule 20A

XVIII. Staffing and Salary Costs

		Reporting Period		Average Hourly Wage
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	
Care Plan Coordinator		2,497	2,652	35.65
Transportation		2,008	2,080	20.71
	TOTAL	4,505	4,732	137,620

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Lisa Hardaman	Administrator	0	\$ 87,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 87,000
B. Administrative - Other			
Description			Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 249,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 249,800
C. Professional Services			
Vendor/Payee	Type		Amount
Ability Network	Computer Services		\$ 4,415
Old Second National Bank	Legal Fees-10/13/20		568
Comcast	Internet Services		1,300
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 6,283
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 31,153
Unemployment Compensation Insurance			24,074
FICA Taxes			168,516
Employee Health Insurance			1,184
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Relations			3,931
Home Office Allocation			38,166
Employee Retirement			1,879
Administrator Benefits			17,400
TOTAL (agree to Schedule V, line 22, col.8)			\$ 286,303
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			
Health Care Worker Background Check (Indicate # of checks performed 3)			
Patient Background Checks 48			1,510
Miscellaneous Licenses & Permits			1,374
Miscellaneous Dues & Subscriptions			0
Home Office Allocation			4,828
Less: Public Relations Expense ()			
Non-allowable advertising ()			
Yellow page advertising ()			
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 7,712
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			
Seminar Expense			
Home Office Allocation			30
Entertainment Expense ()			
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 30

*** Attach copy of IMRF notifications**

****See instructions.**

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Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,283
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	812
Duane Morris	Legal	58,840
Lexis Nexis	Legal	15
Livingston, Barger, Brant, Schroeder	Legal	24,614
Miller, Hall, Triggs	Legal	94
Miscellaneous	Legal	35
SB2	Legal	1,628
SmithAmundsen LLC	Legal	3,879
Sorling Northrup	Legal	931
Capital Finance Group	Legal	7,273
Illinois Secretary of Sate	Legal	260
McGuire Woods	Legal	10,798
CliftonLarsonAllen	Accounting	2,165
Ginoli & Co.	Accounting	7,931
Ability Network	Computer Services	5,559
Allscripts	Computer Services	878
AOD Matrix Care	Computer Services	9,763
AT&T	Computer Services	10
ATS	Computer Services	532
CCH	Computer Services	31
Charter Communications	Computer Services	49
Citrix Systems	Computer Services	166
Comcast	Computer Services	57
ITSavvy	Computer Services	257
Kemper Technology	Computer Services	1,269
Miscellaneous	Computer Services	246
Pearl Technology	Computer Services	230
Stratus Networks	Computer Services	1,008
TR Professional	Computer Services	22
Creative Health Capital	Other Prof Fees	8,734
Mohr and Kerr	Other Prof Fees	15,909
Planning and Zoning Resource Company	Other Prof Fees	2,235
David Budde	Other Prof Fees	22
DJ Howard and Associates	Other Prof Fees	2,094
Getzler Henrich & Associates	Other Prof Fees	2,252
LRI Consulting Services	Other Prof Fees	2,276
McQuellon Consulting	Other Prof Fees	1,402
Miscellaneous	Other Prof Fees	205
Optimizer	Other Prof Fees	90
Registered Agent Solutions	Other Prof Fees	50
RSM McGladrey	Other Prof Fees	551
SB2	Other Prof Fees	705
Sedgwick CMS	Other Prof Fees	58,992
Tarver Program Consultants	Other Prof Fees	131
Total (agree to Schedule V, line 19, column 8)		<u>241,283</u>

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Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	1,865
Auto Repairs		451
Mileage-Travel		2,115
Home Office Allocation		<u>6,756</u>
		<u>11,187</u>

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?
If YES, give association name and amount. No
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period? Yes
7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 14,044 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 241,546
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,134
- (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. \$ 100
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees.