

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

31708 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,710	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,640	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	12,718	1,342	2,955	17,015	8
9	SNF/PED					9
10	ICF	12,861	12,085	30	24,976	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,579	13,427	2,985	41,991	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.59%

D. How many bed-hold days during this year were paid by the Department? 0 (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 1/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 1/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 82 and days of care provided 2,955

Medicare Intermediary Not yet determined

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year YES NO

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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 OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	175,819	17,212	753	193,784		193,784	5,050	198,834		1
2	Food Purchase		184,036		184,036		184,036	(8,185)	175,851		2
3	Housekeeping	92,627	27,005		119,632		119,632	118	119,750		3
4	Laundry	39,813	14,311		54,124		54,124	9	54,133		4
5	Heat and Other Utilities			107,914	107,914		107,914	833	108,747		5
6	Maintenance	46,080	30,593	9,636	86,309		86,309	8,036	94,345		6
7	Other (specify):* Mgmt alloc. of benefits							1,718	1,718		7
8	TOTAL General Services	354,339	273,157	118,303	745,799		745,799	7,579	753,378		8
B. Health Care and Programs											
9	Medical Director			13,345	13,345		13,345		13,345		9
10	Nursing and Medical Records	1,452,328	130,708	30,633	1,613,669		1,613,669	30,700	1,644,369		10
10a	Therapy		5,837	106,928	112,765		112,765	5	112,770		10a
11	Activities	41,178	1,171	3,210	45,559		45,559	16	45,575		11
12	Social Services	82,959	2,064		85,023		85,023		85,023		12
13	CNA Training										13
14	Program Transportation	11,383			11,383		11,383	(100)	11,283		14
15	Other (specify):* Mgmt alloc. of benefits							6,479	6,479		15
16	TOTAL Health Care and Programs	1,587,848	139,780	154,116	1,881,744		1,881,744	37,100	1,918,844		16
C. General Administration											
17	Administrative	108,861		195,000	303,861		303,861	(159,227)	144,634		17
18	Directors Fees										18
19	Professional Services			9,913	9,913		9,913	15,939	25,852		19
20	Dues, Fees, Subscriptions & Promotion			4,311	4,311		4,311	4,823	9,134		20
21	Clerical & General Office Expense	768	8,075	12,704	21,547		21,547	103,270	124,817		21
22	Employee Benefits & Payroll Tax			281,122	281,122		281,122	3,078	284,200		22
23	Inservice Training & Education			2,787	2,787		2,787	1,524	4,311		23
24	Travel and Seminars			250	250		250	1,472	1,722		24
25	Other Admin. Staff Transportation			13,623	13,623		13,623	6,541	20,164		25
26	Insurance-Prop.Liab.Malpractice			62,158	62,158		62,158	3,371	65,529		26
27	Other (specify):* Mgmt alloc. of benefits							23,539	23,539		27
28	TOTAL General Administration	109,629	8,075	581,868	699,572		699,572	4,330	703,902		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,051,816	421,012	854,287	3,327,115		3,327,115	49,009	3,376,124		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			242,489	242,489		242,489	22,580	265,069			30
31	Amortization of Pre-Op. & Org											31
32	Interest			253,603	253,603		253,603	24,162	277,765			32
33	Real Estate Taxes			45,000	45,000		45,000	41	45,041			33
34	Rent-Facility & Grounds							830	830			34
35	Rent-Equipment & Vehicle:			2,190	2,190		2,190	203	2,393			35
36	Other (specify): ³											36
37	TOTAL Ownership			543,282	543,282		543,282	47,816	591,098			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatio											38
39	Ancillary Service Center:			26,890	26,890		26,890		26,890			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shop:											41
42	Provider Participation Fee			74,460	74,460		74,460		74,460			42
43	Other (specify): ³ Nonallowable Costs			50,414	50,414		50,414	(50,414)				43
44	TOTAL Special Cost Centers		26,890	124,874	151,764		151,764	(50,414)	101,350			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,051,816	447,902	1,522,443	4,022,161		4,022,161	46,411	4,068,572			45

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

**See Schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(5,287)	2		4
5	Telephone, TV & Radio in Resident Room	(1,513)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,159	30		9
10	Interest and Other Investment Income	(106)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,599)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual				23
24	Bad Debt	(3,139)	43		24
25	Fund Raising, Advertising and Promotion	(15,672)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See pg 5A	(34,519)	var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (58,676)		\$	30

OHF USE ONLY					
48		49	50	51	52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule	\$		31
32	Donated Goods-Attach Schedule			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	105,087		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 105,087		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 46,411		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 Shop		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Toulon Rehabilitation & Health Care Center

ID# 0046854

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Dues & Subscriptions	\$ (749)	20	1
2	Labs - Part A	(20,524)	43	2
3	X-Rays - Part A	(5,140)	43	3
4	Misc Income Offset	(1,962)	21	4
5	Special Events	(2,827)	43	5
6	Nonallowable legal fees collections	(3,217)	19	6
7	Transportation Income Offset	(100)	14	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	(34,519)		49

-SEE ACCOUNTANTS' COMPILATION REPORT-

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 6A		See Attached Schedule 6A		

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: Adjustments for Related Organization Costs (7 minus 4)		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,050	\$ 5,050	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	160	160	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	114	114	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	9	9	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	769	769	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	6,625	6,625	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,442	1,442	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	8,353	8,353	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	5	5	9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,157	1,157	10	
11	V	17 Administrative	195,000	Petersen Health Care, Inc.	100.00%	35,773	(159,227)	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	10,387	10,387	12	
13	V	20 Due, Fees, Subs & Promos		Petersen Health Care, Inc.	100.00%	4,728	4,728	13	
14	Total		\$ 195,000			\$ 74,572	\$ *	(120,428)	14

* Total must agree with the amount recorded on line 34 of Schedule V1

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	21 Clerical & General Office	\$	Petersen Health Care, Inc.	100.00%	\$ 46,158	\$ 46,158
16	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	750	750
17	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	1,028	1,028
18	V	25 Other Admin. Staff Transport		Petersen Health Care, Inc.	100.00%	3,742	3,742
19	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care, Inc.	100.00%	1,366	1,366
20	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,269	10,269
21	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	6,575	6,575
22	V	32 Interest		Petersen Health Care, Inc.	100.00%	8,847	8,847
23	V	34 Rent - Facility & Grounds		Petersen Health Care, Inc.	100.00%	830	830
24	V	35 Rent - Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	203	203
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 0			\$ 79,768	\$ * 79,768

* Total must agree with the amount recorded on line 34 of Schedule V1

Facility Name & ID Number Toulon Rehabilitation & Health Care Center# 0046854Report Period Beginning: 01/01/2005Ending: 12/31/2005

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	2 Food	\$	Petersen Health Care II, Inc.	0.00%	\$ 20	\$ 20
16	V	3 Housekeeping		Petersen Health Care II, Inc.	0.00%	4	4
17	V	5 Utilities		Petersen Health Care II, Inc.	0.00%	64	64
18	V	6 Maintenance		Petersen Health Care II, Inc.	0.00%	1,411	1,411
19	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	276	276
20	V	10 Nursing & Medical Records		Petersen Health Care II, Inc.	0.00%	22,347	22,347
21	V	11 Activities		Petersen Health Care II, Inc.	0.00%	16	16
22	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	5,322	5,322
23	V	19 Professional Services		Petersen Health Care II, Inc.	0.00%	8,769	8,769
24	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	0.00%	844	844
25	V	21 Clerical & General Office		Petersen Health Care II, Inc.	0.00%	59,074	59,074
26	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	0.00%	774	774
27	V	24 Travel and Seminar		Petersen Health Care II, Inc.	0.00%	444	444
28	V	25 Other Admin. Staff Transport		Petersen Health Care II, Inc.	0.00%	2,799	2,799
29	V	26 Insurance-Prop.Liab.Malpractice		Petersen Health Care II, Inc.	0.00%	2,005	2,005
30	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	0.00%	13,270	13,270
31	V	30 Depreciation		Petersen Health Care II, Inc.	0.00%	12,846	12,846
32	V	32 Interest		Petersen Health Care II, Inc.	0.00%	15,421	15,421
33	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	0.00%	41	41
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 145,747	\$ * 145,747

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

SEE ACCOUNTANTS' COMPILATION REPORT

Toulon Health Care Center
Provider # 0046854
12/31/2005

Schedule 6A

VII Related Parties - Page 6

Related Nursing Homes

City

In-State:

Aledo Rehabilitation & Health Care Center	Aledo, IL
Arcola Health Care Center	Arcola, IL
Arrow Wood Estates of Rock Falls	Rock Falls, IL
Aspen Rehab & Health Care	Silvis, IL
Batavia Rehabilitation & Health Care Center	Batavia, IL
Bement Health Care Center	Bement, IL
Benton Rehabilitation & Health Care Center	Benton, IL
Bloomington Rehabilitation & Health Care Center	Bloomington, IL
Casey Health Care Center	Casey, IL
Cisne Rehabilitation & Health Care Center	Cisne, IL
Countryview Care Center of Macomb	Macomb, IL
Countryview Terrace	Louisville, IL
Decatur Rehabilitation & Health Care Center	Decatur, IL
Eastside Health & Rehabilitation Center	Pittsfield, IL
Eastview Terrace	Sullivan, IL
Effingham Rehabilitation & Health Care Center	Effingham, IL
El Paso Health Care Center	El Paso, IL
Elgin Rehabilitation & Health Care Center	South Elgin, IL
Enfield Rehabilitation & Health Care Center	Enfield, IL
Flora Health Care Center	Flora, IL
Fondulac Rehabilitation & Health Care Center	East Peoria, IL
Havana Health Care Center	Havana, IL
Ironwood Estates of Sandwich	Sandwich, IL
Jonesboro Rehabilitation & Health Care Center	Jonesboro, IL
Kewanee Care Home	Kewanee, IL
McLeansboro Rehabilitation & Health Care Center	McLeansboro, IL
Newman Rehabilitation & Health Care Center	Newman, IL
North Aurora Care Center	Aurora, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Rock Falls Rehabilitation & Health Care Center	Rock Falls, IL
Rosiclare Rehabilitation & Health Care Center	Rosiclare, IL
Royal Oaks Care Center	Kewanee, IL
Sandwich Rehabilitation & Health Care Center	Sandwich, IL
Shelbyville Rehabilitation & Health Care Center	Shelbyville, IL
Sheldon Health Care Center	Sheldon, IL
Sugar Creek Care Center	Watseka, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL
Timbercreek Rehabilitation & Health Care Center	Pekin, IL
Toulon Rehabilitation & Health Care Center	Toulon, IL
Tuscola Health Care Center	Tuscola, IL
Vandalia Rehabilitation & Health Care Center	Vandalia, IL
Watska Rehabilitation & Health Care Center	Watska, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Kewanee Courtyard Estates	Kewanee, IL
Kewanee Courtyard Village	Kewanee, IL
Monmouth Courtyard Estates	Monmouth, IL
Riverview Estates of Havana	Havana, IL
Simple Blessings	Casey, IL

Other Related Business Entities

Petersen Health Care, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Health Care II, Inc.	Peoria, IL	Management/Bookkeeping
Petersen Enterprises	Peoria, IL	Management/Bookkeeping
Petersen Health Systems	Peoria, IL	Management/Bookkeeping
Petersen Health Operations, L.L.C.	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	4	6.15	Salary	\$ 35,773	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	\$ 35,773		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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

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 West 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	Patient Days	46	\$ 82,166	\$ 81,693	41,991	\$ 5,050	1
2	2	Food	Patient Days	46	2,606		41,991	160	2
3	3	Housekeeping	Patient Days	46	1,857		41,991	114	3
4	4	Laundry	Patient Days	46	144		41,991	9	4
5	5	Utilities	Patient Days	46	12,513		41,991	769	5
6	6	Maintenance	Patient Days	46	107,775	81,080	41,991	6,625	6
7	7	Mgmt. Allocation of Benefits	Patient Days	46	23,459		41,991	1,442	7
8	10	Nursing and Medical Records	Patient Days	46	135,903	130,651	41,991	8,353	8
9	10A	Therapy	Patient Days	46	88		41,991	5	9
10	15	Mgmt. Allocation of Benefits	Patient Days	46	18,830		41,991	1,157	10
11	17	Administrative	Patient Days	46	582,000	582,000	41,991	35,773	11
12	19	Professional Services	Patient Days	46	168,984		41,991	10,387	12
13	20	Dues, Fees, Subs & Promos	Patient Days	46	76,921		41,991	4,728	13
14	21	Clerical & General Office	Patient Days	46	750,958	577,218	41,991	46,158	14
15	23	Inservice Training & Education	Patient Days	46	12,208		41,991	750	15
16	24	Travel & Seminar	Patient Days	46	16,731		41,991	1,028	16
17	25	Other Admin. Staff Transport	Patient Days	46	60,875		41,991	3,742	17
18	26	Insurance-Prop.Liab.Malp.	Patient Days	46	22,218		41,991	1,366	18
19	27	Mgmt. Allocation of Benefits	Patient Days	46	167,067		41,991	10,269	19
20	30	Depreciation	Patient Days	46	106,965		41,991	6,575	20
21	32	Interest	Patient Days	46	143,934		41,991	8,847	21
22	34	Rent - Facility & Grounds	Patient Days	46	13,500		41,991	830	22
23	35	Rent - Equipment & Vehicles	Patient Days	46	3,305		41,991	203	23
24									24
25	TOTALS				\$ 2,511,007	\$ 1,452,642		\$ 154,340	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

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 II, Inc.
 Street Address 830 West 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
1	2	Food	Patient Days	241,523	7	\$ 114	\$ 41,991	\$ 20	1	
2	3	Housekeeping	Patient Days	241,523	7	24	41,991	4	2	
3	5	Utilities	Patient Days	241,523	7	370	41,991	64	3	
4	6	Maintenanc	Patient Days	241,523	7	8,117	6,500	41,991	1,411	4
5	7	Mgmt. Allocation of Benefits	Patient Days	241,523	7	1,587	41,991	276	5	
6	10	Nursing & Medical Records	Patient Days	241,523	7	128,534	125,373	41,991	22,347	6
7	11	Activities	Patient Days	241,523	7	93	41,991	16	7	
8	15	Mgmt. Allocation of Benefits	Patient Days	241,523	7	30,610	41,991	5,322	8	
9	19	Professional Services	Patient Days	241,523	7	50,439	41,991	8,769	9	
10	20	Dues, Fees, Subs & Promotions	Patient Days	241,523	7	4,852	41,991	844	10	
11	21	Clerical & General Office	Patient Days	241,523	7	339,781	312,613	41,991	59,074	11
12	23	Inservice Training & Education	Patient Days	241,523	7	4,454	41,991	774	12	
13	24	Travel & Seminar	Patient Days	241,523	7	2,551	41,991	444	13	
14	25	Other Admin. Staff Transport	Patient Days	241,523	7	16,098	41,991	2,799	14	
15	26	Insurance-Prop.Liab.Malp.	Patient Days	241,523	7	11,534	41,991	2,005	15	
16	27	Mgmt. Allocation of Benefits	Patient Days	241,523	7	76,326	41,991	13,270	16	
17	30	Depreciation	Patient Days	241,523	7	73,886	41,991	12,846	17	
18	32	Interest	Patient Days	241,523	7	88,696	41,991	15,421	18	
19	33	Real Estate Taxes	Patient Days	241,523	7	236	41,991	41	19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS				\$ 838,302	\$ 444,486		\$ 145,747	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	
						Original	Balance					
	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									
	A. Directly Facility Related											
	Long-Term											
1	U.S. Bank		X	Mortgage	varies	1/4/2005	\$ 3,660,000	\$ 3,580,421	12/18/2011	0.0699	\$ 252,513	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,660,000	\$ 3,580,421			\$ 252,513	9
	B. Non-Facility Related*											
10									Interest income offset		(106)	10
11									Home Office Alloc.		24,268	11
12									Amortization of mortgage costs		1,090	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 25,252	14
15	TOTALS (line 9+line14)						\$ 3,660,000	\$ 3,580,421			\$ 277,765	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.) SEE ACCOUNTANTS' COMPILATION REPORT

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Toulon Rehabilitation & Health Care Center COUNTY Stark

FACILITY IDPH LICENSE NUMBER 0031708

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-19-401-037</u>	<u>Part of SE 1/4 Section 19</u>	<u>\$ 0</u>	<u>\$ 0</u>
2. <u>04-19-401-039</u>	<u>Part of SE 1/4 Section 19</u>	<u>\$ 0</u>	<u>\$ 0</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854 Report Period Beginning:

01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 38,000 B. General Construction Type: Exterior Brick & Block Frame _____ 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

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: N/A 2. Number of Years Over Which it is Being Amortized N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	38,000	2005	\$ 150,000	1
2					2
3	TOTALS			\$ 150,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	136	2005	1977	\$ 3,371,115	\$ 107,688	30	\$ 112,370	\$ 4,682	\$ 112,370
5									
6	2005 Home Office Allocation	2005	2005	41,844			785	785	785
7									
8									
Improvement Type**									
9	Parking lot/sidewalks		2005	621,663	41,444	15	41,444		41,444
10	New Carpet		2005	9,194	383	10	383		383
11	Fire Suppression System		2005	9,750	81	10	81		81
12									
13	Home Office Allocation - Land Improvements		2005	2,419			75	75	75
14	Home Office Allocation - Leasehold Improvements		2005	68			3	3	3
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 4,056,053	\$ 149,596		\$ 155,141	\$ 5,545	\$ 155,141	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	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	\$	\$	\$	\$		\$	71
72	Current Year Purchases	878,019	89,393	87,870	(1,523)	3-10	87,870	72
73	Fully Depreciated Assets							73
74	Allocation from Home Office			18,558	18,558			74
75	TOTALS	878,019	89,393	106,428	17,035		87,870	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	Transport	1998 Dodge Maxivan	2005	17,500	3,500	3,500		5	3,500	76
77										77
78										78
79										79
80	TOTALS			17,500	3,500	3,500			3,500	80

E. Summary of Care-Related Asset

	1	2	
	Reference	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)	5,101,572	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	242,489	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	265,069	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	22,580	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	246,511	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					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progres

	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 1

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	Allocated from Home Office				830			6
7	TOTAL				\$ 830			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.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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: \$ 2,393 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	<u>N/A</u>				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.

Toulon Health Care Center
Provider # 0046854
1/1/05 to 12/31/05

Schedule 14A

XVI. SUPPORT SCHEDULE
RENTAL AMOUNT FOR MOVABLE EQUIPMENT

Dishwasher	\$ 875
Oxygen System	27
Bed	468
Copy Machine	820
Home Office Allocation	203
Total (agree to Schedule V, line 35, column 8)	<u>2,393</u>

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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			
	1	2	3	4
	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 Wage (c)				
6 Transportation				
7 Contractual Payment:				
8 CNA Competency Tests				
9 TOTALS	\$	\$	\$	\$
10 SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit.
- (c) For in-house training programs only. Do not include fringe benefit.
- (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

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	

- (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.

SEE ACCOUNTANTS' COMPILATION REPORT

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	545	\$ 35,314	\$	545	\$ 35,314	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		70	5,084		70	5,084	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10, C2, C3	hrs		956	66,530	5,837	956	72,367	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				21,297		21,297	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Oxygen	L39, C2					5,593		5,593	13
14	TOTAL			\$	1,571	\$ 106,928	\$ 32,727	1,571	\$ 139,655	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 1,443	\$ 1,443	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	608,278	608,278	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,117	5,117	6
7	Other Prepaid Expenses	18,687	18,687	7
8	Accounts Receivable (owners or related parties)	(228)	(228)	8
9	Other(specify): <u>Meals on Wheels</u>	(346)	(346)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 632,951	\$ 632,951	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	150,000	150,000	13
14	Buildings, at Historical Cost	3,371,115	3,412,959	14
15	Leasehold Improvements, at Historical Cost	640,607	643,094	15
16	Equipment, at Historical Cost	895,519	895,519	16
17	Accumulated Depreciation (book methods)	(242,489)	(246,511)	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 (sp. See Schedule 17A)	273,299	273,299	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,088,051	\$ 5,128,360	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,721,002	\$ 5,761,311	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,061,575	\$ 1,061,575	26
27	Officer's Accounts Payable	1,980	1,980	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	138,753	138,753	30
31	Accrued Taxes Payable (excluding real estate taxes)	30,453	30,453	31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,000	45,000	32
33	Accrued Interest Payable	20,915	20,915	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
36	Other Current Liabilities(specify):			36
37	<u>Accrued Expenses</u>	11,820	11,820	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,310,496	\$ 1,310,496	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,580,421	3,580,421	40
41	Bonds Payable			41
42	Deferred Compensation			42
43	Other Long-Term Liabilities(specify):			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,580,421	\$ 3,580,421	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,890,917	\$ 4,890,917	46
47	TOTAL EQUITY(page 18, line 24)	\$ 830,085	\$ 870,394	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,721,002	\$ 5,761,311	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Toulon Rehabilitation & Health Care Center

Provider #: 0046854

01/01/2005 to 12/31/2005

Schedule 17A

XV. Balance Sheet. SUPPORT SCHEDULE

	<u>Operating</u>	<u>After Consolidation</u>
Line 22 - Other Long-Term Assets		
Goodwill	266,772	266,772
Loan Costs	6,527	6,527
	<u>273,299</u>	<u>273,299</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (219)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (219)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	830,304	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)	\$ 830,304	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)	\$ 830,085	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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 expenses.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,393,447	1
2	Discounts and Allowances for all Levels	68,833	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,462,280	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	226,796	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 226,796	8
C. Other Operating Revenue			
9	Payments for Educator		9
10	Other Government Grants		10
11	CNA Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	4,181	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	93,016	17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	62,918	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 160,115	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income**	106	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 106	26
E. Other Revenue (specify):****			
27	Transportation	100	27
28	Vending	1,047	28
28a	Miscellaneous	2,021	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,168	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,852,465	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	745,799	31
32	Health Care	1,881,744	32
33	General Administration	699,572	33
B. Capital Expense			
34	Ownership	543,282	34
C. Ancillary Expense			
35	Special Cost Centers	77,304	35
36	Provider Participation Fee	74,460	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,022,161	40
41	Income before Income Taxes (line 30 minus line 40)**	830,304	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 830,304	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.
This entity is a cash basis taxpayer.

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

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

Facility Name & ID Number **Toulon Rehabilitation & Health Care Center**

0046854

Report Period Beginning: **01/01/2005**

Ending:

12/31/2005

VIII. 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	\$ 57,464	\$ 27.63	1
2	Assistant Director of Nursing	2,080	2,080	46,472	22.34	2
3	Registered Nurses	6,959	6,959	125,947	18.10	3
4	Licensed Practical Nurses	24,709	24,709	471,148	19.07	4
5	CNAs & Orderlies	72,466	72,466	662,282	9.14	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,290	1,290	15,607	12.10	8
9	Activity Director	2,075	2,075	20,828	10.04	9
10	Activity Assistants	1,988	1,988	20,350	10.24	10
11	Social Service Worker	5,824	5,824	82,959	14.24	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	28,414	13.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,585	16,585	147,405	8.89	15
16	Dishwashers					16
17	Maintenance Worker	3,199	3,199	46,080	14.40	17
18	Housekeepers	11,270	11,365	92,627	8.15	18
19	Laundry	5,514	5,514	39,813	7.22	19
20	Administrator	2,080	2,080	84,479	40.61	20
21	Assistant Administrator	1,976	1,976	24,382	12.34	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	70	70	768	10.97	24
25	Vocational Instructor					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	2,087	2,087	25,064	12.01	31
32	Other Health C: Care Coord.	2,049	2,049	48,344	23.59	32
33	Other(specify) <u>Transp.</u>	1,566	1,566	11,383	7.27	33
34	TOTAL (lines 1 - 33)	167,947	168,042	\$ 2,051,816 *	\$ 12.21	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	19	\$ 753	L1,3	35
36	Medical Director	25 visits	13,345	L9,3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	10 visits	1,170	L10,3	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) <u>Rehab Consultant</u>	585	29,463	L10,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	604	\$ 44,731		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	
Tracy Owens	Administrator	0	\$ 84,479	Workers' Compensation Insurance	\$ 45,582	IDPH License Fee	\$ 951	
Marsha Jacobs	Asst. Administrator	0	24,382	Unemployment Compensation Insurance	52,591	Advertising: Employee Recruitment	826	
				FICA Taxes	139,445	Health Care Worker Background Check		
				Employee Health Insurance	37,954	(Indicate # of checks performed 108)	1,303	
				Employee Meals	3,078	Stark County Health Dept	115	
				Illinois Municipal Retirement Fund (IMRF)*	0	Secretary of State	78	
				Employee Relations	4,786	Newspaper subscriptions	124	
				Life Insurance	434	Other dues and subscriptions	165	
				Physicals	330			
TOTAL (agree to Schedule V, line 17, col. 1)						Home Office Allocation	5,572	
(List each licensed administrator separately.)			\$ 108,861			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
Management Fees (eliminated in Column 7)			\$ 195,000					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 195,000					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Barash & Everett	Legal		\$ 3,217				Out-of-State Travel	\$
Lindon Engineering Services	Engineering Consultant		3,807					
Advanced Answers on Demand	Computer		476				In-State Travel	90
LTC Solutions, Inc.	Computer		1,979					
IVANS	Computer		334	N/A				
Mediacom	Computer		100				Seminar Expense	160
							Home Office Allocation	1,472
							Entertainment Expense	()
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 9,913				TOTAL	\$ 1,722

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Toulon Health Care Center
Provider # 0046854
1/1/05 to 12/31/05

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	9,913
Nonallowable legal fees - collections	(3,217)
Allocated from Management Company	
Legal	197
Other	18,959
Total (agree to Schedule V, line 19, column 8)	<u><u>25,852</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5										
				6										
1	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year									
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010	
2			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	
3														
4														
5	N/A													
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														
18														
19														
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Toulon Rehabilitation & Health Care Center# 0046854Report Period Beginning: 01/01/2005 Ending: 12/31/2005**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 No
If YES, give association name and amount N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Sch. V. 467 Line 10,2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 74,460
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 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 if 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. \$ 3,078 Has any meal income been offset against related costs? Yes Indicate the amount \$ 5,287
- (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 program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. In progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT

RECONCILIATION REPORT

12:13 PM 5/16/2006

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	46,411	equal to	46,411	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	277,765	equal to	277,765	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	45,041	equal to	45,041	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	265,069	equal to	265,069	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	830	equal to	830	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,393	equal to	2,393	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	112,765	equal to	112,765	0	O.K.	Pg16 Z12+Z14.	N/A/B	1-4;40-43	8:2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	32,727	equal to	32,727	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39.10a	2
Income Stat. General Serv.	745,799	equal to	745,799	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,881,744	equal to	1,881,744	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Administration	699,572	equal to	699,572	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	543,282	equal to	543,282	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	77,304	equal to	77,304	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+i	N/A	38to41+43	4
Income Stat. Prov. Partic.	74,460	equal to	74,460	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	#REF!	equal to	1,452,328	#REF!	#REF!	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	41,178	equal to	41,178	0	O.K.	Pg20 K19+K20	A.	9-10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	82,959	equal to	82,959	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	175,819	equal to	175,819	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	46,080	equal to	46,080	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	92,627	equal to	92,627	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	39,813	equal to	39,813	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	108,861	equal to	108,861	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	768	equal to	768	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,051,816	equal to	2,051,816	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	753	< or = to	753	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	13,345	< or = to	13,345	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	30,633	< or = to	30,633	0	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to6	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	3,210	-3,210	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	108,861	equal to	108,861	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	195,000	equal to	195,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	9,913	equal to	9,913	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	284,200	equal to	284,200	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	9,134	equal to	9,134	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,722	equal to	1,722	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	74,460	equal to	74,460	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	3,078	< or = to	3,078	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	3,078	equal to	3,078	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	2,955	equal to	2,955	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	105,087	equal to	105,087	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4	B.	14	8
Total loan balance	3,580,421	equal to	3,580,421	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	45,000	equal to	45,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	150,000	equal to	150,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	4,056,053	equal to	4,056,053	0	O.K.	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	895,519	equal to	895,519	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	246,511	equal to	246,511	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	830,085	equal to	830,085	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	830,304	equal to	830,304	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..l	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	5,721,002	equal to	5,721,002	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Toulon Rehabilitation & Health Care Center
IDHFS Comparative Data - Per Resident Day Cost
Year Ending 12/31/2005

Enter your HSA # in next column
 Census (Pulls from Page 2)

Cost Report Line	Description	Average Median Cost Per Day (2003)		
		Year Facility	State	HSA
1	Dietary	4.74	6.01	6.48
2	Food Purchase	4.19	4.31	4.40
3	Housekeeping	2.85	3.70	3.68
4	Laundry	1.29	1.85	1.90
5	Heat & Other Utilities	2.59	2.95	2.93
6	Maintenance	2.25	3.01	3.03
8	Total General Services	17.94	22.58	22.99
10	Nursing & Medical Records	39.16	41.83	43.12
10A	Therapy	2.69	2.10	2.69
11	Activities	1.09	1.91	1.92
12	Social Services	2.02	1.42	1.64
16	Total Health Care & Programs	45.70	49.48	51.22
17	Administration	3.44	3.36	3.15
19	Professional Services	0.62	0.99	0.85
21	Clerical & Gen. Office Expense	2.97	4.79	4.97
22	Employee Benefits & PR Taxes	6.77	10.09	11.01
24	Travel & Seminar	0.04	0.08	0.13
26	Insurance-Property, Liability & Malpractice	1.56	2.58	2.55
28	Total General Administrative	16.76	24.94	26.11
29	Total Operating Expenses	80.40	98.06	100.03
30	Depreciation	6.31	3.70	4.08
32	Interest	6.61	2.54	1.96
33	Real Estate Taxes	1.07	1.38	1.08
37	Total Ownership	14.08	11.11	9.80
	Total Operating and Ownership Cost	94.48	109.17	109.83

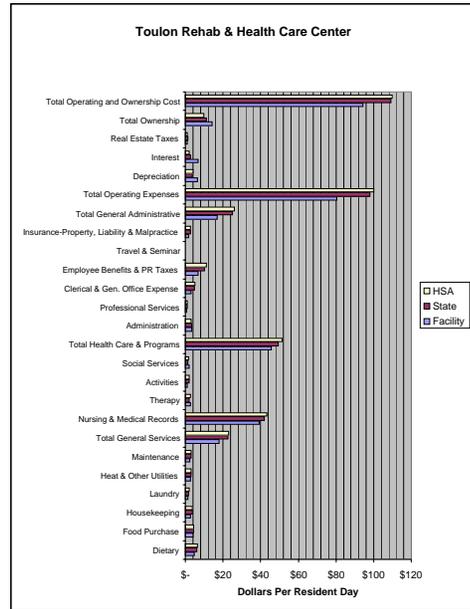
Notes:
 Your Facility data is from page 3, column 8 of your 2005 Medicaid cost report, divided by your annual census.
 The Average Median Cost Per Day for the State and your HSA is taken from 2003 data available from the Illinois Department of Healthcare and Family Services and corresponds with the respective cost report data after final adjustments.

IDHFS LTC Profiles

LTC Median Per Diem Cost by HSA - 2003 Cost Reports
2003 (Run June 1, 2004)

UN-INFLATED

Cost Report Line	Description	State-Wide	HSA											10th %	90th %	
			1	2	3	4	5	6	7	8	9	10	11			
1	Dietary	6.01	7.02	6.48	5.50	6.48	5.48	6.06	6.06	6.06	5.60	7.02	5.70	-	4.13	9.81
2	Food Purchase	4.31	4.47	4.40	4.27	4.40	3.99	4.31	4.31	4.31	4.28	4.47	4.11	-	3.56	6.04
3	Housekeeping	3.70	3.59	3.68	2.91	3.68	3.40	4.05	4.05	4.05	3.97	3.59	3.61	-	2.48	5.80
4	Laundry	1.85	2.23	1.90	1.79	1.90	2.10	1.59	1.59	1.59	1.69	2.23	2.13	-	0.91	3.14
5	Heat & Other Utilities	2.95	3.17	2.93	2.94	2.93	2.71	2.93	2.93	2.93	2.91	3.17	2.95	-	2.05	4.25
6	Maintenance	3.01	3.26	3.03	2.99	3.03	2.55	3.21	3.21	3.21	3.05	3.26	2.82	-	1.92	5.12
8	TOTAL GENERAL SERVICES	22.58	24.49	22.99	21.14	22.99	21.47	22.65	22.65	22.65	22.45	24.49	21.73	-	17.57	31.51
10	Nursing & Medical Records	41.83	42.52	43.12	38.37	43.12	33.78	45.12	45.12	45.12	47.22	42.52	42.15	-	27.25	64.47
10A	Therapy	2.10	1.86	2.69	3.34	2.69	3.47	1.45	1.45	1.45	2.41	1.86	2.24	-	-	10.55
11	Activities	1.91	2.18	1.92	1.61	1.92	1.48	2.16	2.16	2.16	2.05	2.18	1.54	-	1.06	3.45
12	Social Services	1.42	1.45	1.64	1.05	1.64	1.09	1.60	1.60	1.60	1.12	1.45	1.27	-	0.58	3.00
16	TOTAL HEALTH CARE & PROGRAMS	49.48	50.39	51.22	46.39	51.22	41.58	52.34	52.34	52.34	54.96	50.39	49.49	-	32.10	77.23
17	Administration	3.36	3.33	3.15	3.15	3.15	3.60	3.46	3.46	3.46	3.04	3.33	3.17	-	1.71	7.21
19	Professional Services	0.99	1.09	0.85	0.83	0.85	0.76	1.12	1.12	1.12	1.13	1.09	0.77	-	0.07	3.44
21	Clerical & Gen. Office Expense	4.79	4.32	4.97	3.98	4.97	3.46	5.56	5.56	5.56	5.04	4.32	4.25	-	2.49	10.78
22	Employee Benefits & PR Taxes	10.09	10.42	11.01	8.88	11.01	7.67	10.51	10.51	10.51	11.38	10.42	9.08	-	6.33	19.34
24	Travel & Seminar	0.08	0.10	0.13	0.10	0.13	0.13	0.06	0.06	0.06	0.05	0.10	0.07	-	-	0.43
26	Insurance-Property, liability & Malpractice	2.58	2.47	2.55	2.35	2.55	2.22	2.85	2.85	2.85	2.19	2.47	2.61	-	0.88	4.32
28	TOTAL GENERAL ADMINISTRATIVE	24.94	25.31	26.11	23.02	26.11	21.37	25.81	25.81	25.81	26.59	25.31	22.93	-	16.95	39.14
29	TOTAL OPERATING EXPENSES	98.06	100.77	100.03	92.47	100.03	88.05	100.96	100.96	100.96	103.01	100.77	94.71	-	69.40	142.56
30	Depreciation	3.70	3.82	4.08	3.29	4.08	2.54	4.11	4.11	4.11	3.54	3.82	3.38	-	1.01	8.43
32	Interest	2.54	2.81	1.96	2.09	1.96	1.41	4.05	4.05	4.05	2.63	2.81	1.50	-	-	11.53
33	Real Estate Taxes	1.38	0.92	1.08	0.82	1.08	0.80	3.20	3.20	3.20	1.36	0.92	1.11	-	-	4.85
37	TOTAL OWNERSHIP	11.11	9.73	9.80	8.00	9.80	7.04	14.54	14.54	14.54	11.02	9.73	8.39	-	3.76	23.58
	TOTAL OPERATING & OWNERSHIP CC	109.17	110.50	109.83	100.47	109.83	95.09	115.50	115.50	115.50	114.03	110.50	103.10	-	73.16	166.14



	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	175,819	17,212	753	193,784	0	193,784	5,050	198,834
2. Food Purchase	0	184,036	0	184,036	0	184,036	-8,185	175,851
3. Housekeeping	92,627	27,005	0	119,632	0	119,632	118	119,750
4. Laundry	39,813	14,311	0	54,124	0	54,124	9	54,133
5. Heat and Other Utilities	0	0	107,914	107,914	0	107,914	833	108,747
6. Maintenance	46,080	30,593	9,636	86,309	0	86,309	8,036	94,345
7. Other (specify)*	0	0	0	0	0	0	1,718	1,718
8. Total General Services	354,339	273,157	118,303	745,799	0	745,799	7,579	753,378
9. Medical Director	0	0	13,345	13,345	0	13,345	0	13,345
10. Nursing & Medical Records	1,452,328	130,708	30,633	1,613,669	0	1,613,669	30,700	1,644,369
10a. Therapy	0	5,837	106,928	112,765	0	112,765	5	112,770
11. Activities	41,178	1,171	3,210	45,559	0	45,559	16	45,575
12. Social Services	82,959	2,064	0	85,023	0	85,023	0	85,023
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	11,383	0	0	11,383	0	11,383	-100	11,283
15. Other (specify)*	0	0	0	0	0	0	6,479	6,479
16. Total Health Care & Programs	1,587,848	139,780	154,116	1,881,744	0	1,881,744	37,100	1,918,844
17. Administrative	108,861	0	195,000	303,861	0	303,861	-159,227	144,634
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	9,913	9,913	0	9,913	15,939	25,852
20. Fees, Subscriptions & Promotion	0	0	4,311	4,311	0	4,311	4,823	9,134
21. Clerical & General Office	768	8,075	12,704	21,547	0	21,547	103,270	124,817
22. Employee Benefits & Payroll	0	0	281,122	281,122	0	281,122	3,078	284,200
23. Inservice Training & Education	0	0	2,787	2,787	0	2,787	1,524	4,311
24. Travel and Seminar	0	0	250	250	0	250	1,472	1,722
25. Other Admin. Staff Trans	0	0	13,623	13,623	0	13,623	6,541	20,164
26. Insurance-Prop.Liab.Malpractice	0	0	62,158	62,158	0	62,158	3,371	65,529
27. Other (specify)*	0	0	0	0	0	0	23,539	23,539
28. Total General Adminis	109,629	8,075	581,868	699,572	0	699,572	4,330	703,902
29. Total General Administrative	2,051,816	421,012	854,287	3,327,115	0	3,327,115	49,009	3,376,124
30. Depreciation	0	0	242,489	242,489	0	242,489	22,580	265,069
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	253,603	253,603	0	253,603	24,162	277,765
33. Real Estate	0	0	45,000	45,000	0	45,000	41	45,041
34. Rent - Facility & Grounds	0	0	0	0	0	0	830	830
35. Rent - Equipment & Vehicles	0	0	2,190	2,190	0	2,190	203	2,393
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	543,282	543,282	0	543,282	47,816	591,098
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	26,890	0	26,890	0	26,890	0	26,890
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	74,460	74,460	0	74,460	0	74,460
43. Other (specify):*	0	0	50,414	50,414	0	50,414	-50,414	0
44. Total Special Cost Ce	0	26,890	124,874	151,764	0	151,764	-50,414	101,350
45. Grand Total	2,051,816	447,902	1,522,443	4,022,161	0	4,022,161	46,411	4,068,572

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,443	1,443
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	608,278	608,278
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	5,117	5,117
7. Other Prepaid Expenses	18,687	18,687
8. Accounts Receivable-Owner/Related Party	-228	-228
9. Other (specify):	-346	-346
10. Total current assets	632,951	632,951
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	150,000	150,000
14. Buildings, at Historical Cost	3,371,115	3,412,959
15. Leasehold Improvements, Historical Cost	640,607	643,094
16. Equipment, at Historical Cost	895,519	895,519
17. Accumulated Depreciation (book methods)	-242,489	-246,511
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	273,299	273,299
23. other (specify):	0	0
24. Total Long-Term Assets	5,088,051	5,128,360
25. Total Assets	5,721,002	5,761,311
CURRENT LIABILITIES		
26. Accounts Payable	1,061,575	1,061,575
27. Officer's Accounts Payable	1,980	1,980
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	138,753	138,753
31. Accrued Taxes Payable	30,453	30,453
32. Accrued Real Estate Taxes	45,000	45,000
33. Accrued Interest Payable	20,915	20,915
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	11,820	11,820
38. Total Current Liabilities	1,310,496	1,310,496
LONG TERM LIABILITES		
39. Long-Term Notes Payable	0	0
40. Mortgage Payable	3,580,421	3,580,421
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	3,580,421	3,580,421
46. Total Liabilities	4,890,917	4,890,917
47. Total Equity	830,085	870,394
48. Total Liabilities and Equity	5,721,002	5,761,311

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	4,393,447
2. Discounts and Allowances for all Levels	68,833
Subtotal - Inpatient Care	4,462,280
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	226,796
7. Oxygen	0
Subtotal - Ancillary Revenue	226,796
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	4,181
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	93,016
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	62,918
22. Laundry	0
Subtotal - Other Operating Revenue	160,115
24. Contributions	0
25. Interest and Other Investments Income	106
Subtotal - Non-Operating Revenue	106
27. Other Revenue (specify):	3,168
28. Other Revenue (specify):	0
Subtotal - Other Revenue	3,168
30. Total Revenue	4,852,465
31. General Services	745,799
32. Health Care	1,881,744
33. General Administration	699,572
34. Ownership	543,282
35. Special Cost Centers	77,304
35. Provider Participation Fee	74,460
37. Other	0
40. Total Expenses	4,022,161
41. Income Before Income Taxes	830,304
42. Income Taxes	0
43. Net Income or Loss for the Year	830,304