



Facility Name & ID Number Toulon Rehabilitation & Health Care Center

# 0046854 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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			3,595	3,595	8
9	SNF/PED					9
10	ICF	21,988	11,691		33,679	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,988	11,691	3,595	37,274	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.09%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 1/1/05

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

YES

Date 1/1/05

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 3,595

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH\*

CASH\*

Is your fiscal year identical to your tax year?

YES  NO

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

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

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	187,147	20,647		207,794		207,794	3,119	210,913		1
2	Food Purchase		217,308		217,308		217,308	(9,190)	208,118		2
3	Housekeeping	109,562	28,835		138,397		138,397	35	138,432		3
4	Laundry	53,104	14,078		67,182		67,182	2	67,184		4
5	Heat and Other Utilities			150,294	150,294		150,294	533	150,827		5
6	Maintenance	43,432	14,338	27,555	85,325		85,325	5,216	90,541		6
7	Other (specify):* Home Off. Ben. All.							1,423	1,423		7
8	<b>TOTAL General Services</b>	393,245	295,206	177,849	866,300		866,300	1,138	867,438		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	1,464,167	94,716	16,105	1,574,988		1,574,988	8,247	1,583,235		10
10a	Therapy	16,759	1,991	290,904	309,654		309,654		309,654		10a
11	Activities	50,668	1,471	8,603	60,742		60,742		60,742		11
12	Social Services	50,561	125		50,686		50,686		50,686		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,834	1,834		15
16	<b>TOTAL Health Care and Programs</b>	1,582,155	98,303	328,812	2,009,270		2,009,270	10,081	2,019,351		16
	<b>C. General Administration</b>										
17	Administrative	57,898		190,000	247,898		247,898	(166,781)	81,117		17
18	Directors Fees										18
19	Professional Services			10,809	10,809		10,809	10,554	21,363		19
20	Dues, Fees, Subscriptions & Promotions			8,794	8,794		8,794	1,852	10,646		20
21	Clerical & General Office Expenses	19,983	9,159	13,006	42,148		42,148	63,096	105,244		21
22	Employee Benefits & Payroll Taxes			268,547	268,547		268,547	12,209	280,756		22
23	Inservice Training & Education			240	240		240	641	881		23
24	Travel and Seminar			1,390	1,390		1,390	1,017	2,407		24
25	Other Admin. Staff Transportation			12,305	12,305		12,305	5,839	18,144		25
26	Insurance-Prop.Liab.Malpractice			23,145	23,145		23,145	3,669	26,814		26
27	Other (specify):* Home Off. Ben. All.							15,117	15,117		27
28	<b>TOTAL General Administration</b>	77,881	9,159	528,236	615,276		615,276	(52,787)	562,489		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,053,281	402,668	1,034,897	3,490,846		3,490,846	(41,568)	3,449,278		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

#0046854

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			261,929	261,929		261,929	17,790	279,719			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			240,841	240,841		240,841	28,100	268,941			32
33	Real Estate Taxes			127,024	127,024		127,024	1,220	128,244			33
34	Rent-Facility & Grounds							75	75			34
35	Rent-Equipment & Vehicles			8,339	8,339		8,339	1,013	9,352			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			638,133	638,133		638,133	48,198	686,331			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		129,630		129,630		129,630		129,630			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,460	74,460		74,460		74,460			42
43	Other (specify):* Non-allowable Cost	21,291	1,617	126,544	149,452		149,452	(149,452)				43
44	<b>TOTAL Special Cost Centers</b>	21,291	131,247	201,004	353,542		353,542	(149,452)	204,090			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,074,572	533,915	1,874,034	4,482,521		4,482,521	(142,822)	4,339,699			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.

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(9,298)	2		4
5	Telephone, TV & Radio in Resident Rooms	(100)	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	(7,514)	30		9
10	Interest and Other Investment Income	(84)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,238)	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	(3,640)	43		18
19	Entertainment				19
20	Contributions	(2,160)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,060)	43		24
25	Fund Raising, Advertising and Promotional	(19,304)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(47,451)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (167,849)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	25,027	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 25,027		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (142,822)		37

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

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

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

Toulon Rehabilitation & Health Care CenterID# 0046854Report Period Beginning: 01/01/2007Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (18,521)	43	1
2	X-Rays-Part A	(2,713)	43	2
3	Disallowed Special Events	(1,702)	43	3
4	Resident Flower	(1,723)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(998)	21	5
6	Offset Chamber of Commerce Dues	(503)	20	6
7	Disallowed Marketing Salaries	(21,291)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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35				35
36				36
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38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(47,451)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Toulon Rehabilitation & Health Care Center# 0046854

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
		(to Sch V, col.7)												
1	Dietary	0	3,119	0	0	0	0	0	0	0	0	0	3,119	1
2	Food Purchase	(9,298)	108	0	0	0	0	0	0	0	0	0	(9,190)	2
3	Housekeeping	0	35	0	0	0	0	0	0	0	0	0	35	3
4	Laundry	0	2	0	0	0	0	0	0	0	0	0	2	4
5	Heat and Other Utilities	0	533	0	0	0	0	0	0	0	0	0	533	5
6	Maintenance	0	4,345	0	871	0	0	0	0	0	0	0	5,216	6
7	Other (specify):*	0	1,423	0	0	0	0	0	0	0	0	0	1,423	7
8	<b>TOTAL General Services</b>	<b>(9,298)</b>	<b>9,565</b>	<b>0</b>	<b>871</b>	<b>0</b>	<b>1,138</b>	<b>8</b>						
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	8,247	0	0	0	0	0	0	0	0	0	8,247	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,834	0	0	0	0	0	0	0	0	0	1,834	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>10,081</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>10,081</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(166,781)	0	0	0	0	0	0	0	0	0	(166,781)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,303	0	4,251	0	0	0	0	0	0	0	10,554	19
20	Fees, Subscriptions & Promotions	(503)	0	1,366	989	0	0	0	0	0	0	0	1,852	20
21	Clerical & General Office Expenses	(998)	0	52,871	11,223	0	0	0	0	0	0	0	63,096	21
22	Employee Benefits & Payroll Taxes	0	0	0	12,209	0	0	0	0	0	0	0	12,209	22
23	Inservice Training & Education	0	0	608	33	0	0	0	0	0	0	0	641	23
24	Travel and Seminar	0	0	968	49	0	0	0	0	0	0	0	1,017	24
25	Other Admin. Staff Transportation	0	0	3,506	2,333	0	0	0	0	0	0	0	5,839	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,428	2,241	0	0	0	0	0	0	0	3,669	26
27	Other (specify):*	0	0	15,117	0	0	0	0	0	0	0	0	15,117	27
28	<b>TOTAL General Administration</b>	<b>(1,501)</b>	<b>(160,478)</b>	<b>75,864</b>	<b>33,328</b>	<b>0</b>	<b>(52,787)</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(10,799)</b>	<b>(140,832)</b>	<b>75,864</b>	<b>34,199</b>	<b>0</b>	<b>(41,568)</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,514)	0	3,702	21,602	0	0	0	0	0	0	0	17,790	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(84)	0	6,435	21,749	0	0	0	0	0	0	0	28,100	32
33	Real Estate Taxes	0	0	1,220	0	0	0	0	0	0	0	0	1,220	33
34	Rent-Facility & Grounds	0	0	75	0	0	0	0	0	0	0	0	75	34
35	Rent-Equipment & Vehicles	0	0	982	31	0	0	0	0	0	0	0	1,013	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(7,598)</b>	<b>0</b>	<b>12,414</b>	<b>43,382</b>	<b>0</b>	<b>48,198</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(149,452)	0	0	0	0	0	0	0	0	0	0	(149,452)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(149,452)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(149,452)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(167,849)</b>	<b>(140,832)</b>	<b>88,278</b>	<b>77,581</b>	<b>0</b>	<b>(142,822)</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,119	\$ 3,119	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	108	108	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	35	35	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	533	533	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	4,345	4,345	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,423	1,423	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	8,247	8,247	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,834	1,834	10
11	V	17 Administrative	190,000	Petersen Health Care, Inc.	100.00%	23,219	(166,781)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,303	6,303	12
13	V							13
14	Total		\$ 190,000			\$ 49,168	\$ * (140,832)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,366	\$	1,366	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	52,871		52,871	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	608		608	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	968		968	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,506		3,506	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,428		1,428	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	15,117		15,117	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,702		3,702	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	6,435		6,435	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,220		1,220	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	75		75	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	982		982	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 88,278	\$ *	88,278	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Care II, Inc.	100.00%	\$ 0	\$ 0
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0	0
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0	0
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0	0
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0	0
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	871	871
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0	0
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0	0
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	4,251	4,251
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	989	989
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	11,223	11,223
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	12,209	12,209
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	33	33
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	49	49
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	2,333	2,333
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	2,241	2,241
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0	0
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	21,602	21,602
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	21,749	21,749
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0	0
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0	0
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	31	31
39	Total		\$			\$ 77,581	\$ * 77,581

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

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.53	2.78	Salary	\$ 23,219	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	\$ 23,219		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 Toulon Rehabilitation & Health Care Center

# 0046854

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	37,274	\$ 3,119	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	37,274	108	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	37,274	35	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	37,274	2	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	37,274	533	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	37,274	4,345	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	37,274	1,423	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	37,274	8,247	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	37,274	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	37,274	1,834	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	37,274	23,219	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	37,274	6,303	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	37,274	1,366	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	37,274	52,871	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	37,274	608	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	37,274	968	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	37,274	3,506	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	37,274	1,428	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	37,274	15,117	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	37,274	3,702	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	37,274	6,435	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	37,274	1,220	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	37,274	75	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	37,274	982	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 137,446	25

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

# 0046854

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	340,686	11	\$	37,274	\$	1
2	2	Food	Resident Days	340,686	11		37,274		2
3	3	Housekeeping	Resident Days	340,686	11		37,274		3
4	4	Laundry	Resident Days	340,686	11		37,274		4
5	5	Utilities	Resident Days	340,686	11		37,274		5
6	6	Maintenance	Resident Days	340,686	11	7,966	37,274	871	6
7	7	Mgmt. Allocation of Benefits	Resident Days	340,686	11		37,274		7
8	10	Nursing and Medical Records	Resident Days	340,686	11		37,274		8
9	15	Mgmt. Allocation of Benefits	Resident Days	340,686	11		37,274		9
10	17	Administrative	Resident Days	340,686	11		37,274		10
11	19	Professional Services	Resident Days	340,686	11	38,857	37,274	4,251	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	340,686	11	9,036	37,274	989	12
13	21	Clerical and General Office	Resident Days	340,686	11	102,581	37,274	11,223	13
14	22	Employee Benefits & Payroll	Resident Days	340,686	11	111,591	37,274	12,209	14
15	23	Inservice Training & Education	Resident Days	340,686	11	300	37,274	33	15
16	24	Travel and Seminar	Resident Days	340,686	11	451	37,274	49	16
17	25	Other Admin. Staff Transport.	Resident Days	340,686	11	21,324	37,274	2,333	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	340,686	11	20,484	37,274	2,241	18
19	27	Mgmt. Allocation of Benefits	Resident Days	340,686	11		37,274		19
20	30	Depreciation	Resident Days	340,686	11	197,442	37,274	21,602	20
21	32	Interest	Resident Days	340,686	11	198,787	37,274	21,749	21
22	33	Real Estate Taxes	Resident Days	340,686	11		37,274		22
23	34	Rent-Facility and Grounds	Resident Days	340,686	11		37,274		23
24	35	Rent-Equipment & Vehicles	Resident Days	340,686	11	280	37,274	31	24
25	TOTALS					\$ 709,099	\$	\$ 77,581	25

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

# 0046854

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

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

1	Name of Lender	2		3	4	5	6		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1	US Bank		X	Mortgage	Varies	12/9/04	\$ 3,660,000	\$ 3,388,066	12/31/11	Varies	\$ 239,751	1					
2												2					
3							Offset Interest Income				(84)	3					
4							Home Office Allocation-PHC				6,435	4					
5							Home Office Allocation-PHC II				21,749	5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$ 3,660,000	\$ 3,388,066			\$ 267,851	9					
<b>B. Non-Facility Related*</b>																	
10							Amortization of Loan Costs				1,090	10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 1,090	14					
15	<b>TOTALS (line 9+line14)</b>						\$ 3,660,000	\$ 3,388,066			\$ 268,941	15					

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2006 report.		\$	<b>117,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2006	\$	<b>120,024</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>3,024</b>	3
4. Real Estate Tax accrual used for 2007 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>124,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>Home Office Allocation</b>		\$	<b>1,220</b>	6
<b>TOTAL REFUND</b> \$ _____ For _____ Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>128,244</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2002		<b>8</b>	
	2003		<b>9</b>	
	2004		<b>10</b>	
	2005	<b>116,093</b>	<b>11</b>	
	2006	<b>120,024</b>	<b>12</b>	
<b>Accrual based on prior year tax bill.</b>				
<b>FOR BHF USE ONLY</b>				
	13	FROM R. E. TAX STATEMENT FOR 2006	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

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

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

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

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

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

FACILITY NAME Toulon Rehabilitation & Health Care Center COUNTY Stark

FACILITY IDPH LICENSE NUMBER 0046854

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

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

Enter the tax index number and real estate tax assessed for 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-19-401-037</u>	<u>Long-Term Care Facility</u>	\$ <u>2,210.00</u>	\$ <u>2,210.00</u>
2. <u>04-19-401-039</u>	<u>Long-Term Care Facility</u>	\$ <u>117,814.00</u>	\$ <u>117,814.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>120,024.00</u>	\$ <u>120,024.00</u>

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 38,000 B. General Construction Type: Exterior Brick & Block Frame Steel Number of Stories 1

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

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

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

N/A

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

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

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

**XI. OWNERSHIP COSTS:**

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>38,000</u>	<u>2005</u>	<u>\$ 150,000</u>	<u>1</u>
2					<u>2</u>
3	<b>TOTALS</b>	<b>38,000</b>		<b>\$ 150,000</b>	<b>3</b>

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	136	2005	1977	\$ 3,371,115	\$	30	\$ 112,370	\$ 112,370	\$ 337,111
5									
6									
7	Home Office Allocation			20,780			507	507	
8									
<b>Improvement Type**</b>									
9	Parking lot/sidewalks	2005		621,663		15	41,444	41,444	124,332
10	New Carpet	2005		9,194		10	919	919	2,221
11	Fire Suppression System	2005		9,750		10	975	975	2,031
12	Sidewalks	2006		10,292		15	686	686	1,143
13	Water Heater	2007		5,159		10	258	258	258
14	Fire/Door Alarms	2007		2,090		10	105	105	105
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25	Building Booked				112,370			(112,370)	
26	Building Improvement Booked				44,121			(44,121)	
27									
28									
29									
30									
31	2007-Home Office Allocation-Building Improvements			1,390			83	83	
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

**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)	\$ 4,051,433	\$ 156,491		\$ 157,347	\$ 856	\$ 467,201	70

\*\*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 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	\$ 937,128	\$ 100,947	\$ 93,713	\$ (7,234)	3-10	\$ 273,954	71
72	Current Year Purchases	8,893	1,130	445	(685)	10	445	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			24,714	24,714			74
75	TOTALS	\$ 946,021	\$ 102,077	\$ 118,872	\$ 16,795		\$ 274,399	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	Facility Use	1998 Dodge Maxivan	2005	\$ 17,500	\$ 3,361	\$ 3,500	\$ 139	5	\$ 10,500	76
77										77
78										78
79										79
80	TOTALS			\$ 17,500	\$ 3,361	\$ 3,500	\$ 139		\$ 10,500	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)	\$ 5,164,954	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 261,929	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 279,719	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 17,790	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 752,100	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  YES  NO

If NO, see instructions.

	1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:			\$			3
4	Additions						4
5							5
6	<u>Home Office Allocation</u>			<u>75</u>			6
7	<b>TOTAL</b>			\$ <b>75</b>			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: \$ 9,352 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

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

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

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

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

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

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

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

Toulon Rehabilitation & Health Care Center  
0046854

Period Beginning 01/01/2007

Period End 12/31/2007

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

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

Medical Equipment	\$	5,130
Dishwasher		722
Copier		2,487
Home Office Allocation		1,013
		<u>9,352</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10A(3)	hrs	\$	8,270	\$ 124,049						8,270	\$ 124,049			1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,488	22,322						1,488	22,322			2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		9,636	144,533			1,991			9,636	146,524			4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39(2)	# of prescripts						129,630				129,630			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Exceptional Care Program															12
13	Other (specify):															13
14	TOTAL			\$	19,394	\$ 290,904			\$ 131,621			19,394	\$ 422,525			14

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

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

# 0046854

Report Period Beginning: 01/01/2007

Ending:

12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 1,062,732	\$ 1,062,732	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u> )	659,120	659,120	3
4	Supply Inventory (priced at <u>                    </u> )			4
5	Short-Term Investments			5
6	Prepaid Insurance	20,893	20,893	6
7	Other Prepaid Expenses	7,196	7,196	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>                                    </u>			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,749,941</b>	<b>\$ 1,749,941</b>	<b>10</b>
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	781,955	150,000	13
14	Buildings, at Historical Cost	3,371,115	3,391,895	14
15	Leasehold Improvements, at Historical Cost	16,443	659,538	15
16	Equipment, at Historical Cost	963,521	963,521	16
17	Accumulated Depreciation (book methods)	(767,879)	(752,100)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: <u>Goodwill</u> )	266,772	266,772	22
23	Other(specify): <u>Loan Costs</u>	4,360	4,360	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 4,636,287</b>	<b>\$ 4,683,986</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 6,386,228</b>	<b>\$ 6,433,927</b>	<b>25</b>

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 501,518	\$ 501,518	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	140,749	140,749	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,982	8,982	31
32	Accrued Real Estate Taxes(Sch.IX-B)	124,000	124,000	32
33	Accrued Interest Payable	19,735	19,735	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	37,063	37,063	36
37	<u>Due to Related Parties</u>	6,932	6,932	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 838,979</b>	<b>\$ 838,979</b>	<b>38</b>
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,388,066	3,388,066	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>A/P-Prior Owner</u>	2,268	2,268	43
44	<u>  </u>			44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 3,390,334</b>	<b>\$ 3,390,334</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 4,229,313</b>	<b>\$ 4,229,313</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 2,156,915</b>	<b>\$ 2,204,614</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 6,386,228</b>	<b>\$ 6,433,927</b>	<b>48</b>

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,615,189</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Rounding</b>	<b>(2)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,615,187</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>541,728</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>541,728</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,156,915</b>	<b>24</b> *

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

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

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

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 4,107,854	1
2	Discounts and Allowances for all Levels	252,750	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,360,604	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	426,784	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 426,784	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,298	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	205,090	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	12,336	20
21	Other Medical Services	9,055	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 235,779	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	84	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 84	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a	<u>Miscellaneous Revenue</u>	998	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 998	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,024,249	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	866,300	31
32	Health Care	2,009,270	32
33	General Administration	615,276	33
	<b>B. Capital Expense</b>		
34	Ownership	638,133	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	279,082	35
36	Provider Participation Fee	74,460	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,482,521	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	541,728	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 541,728	43

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

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

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

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

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

# 0046854

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 60,051	\$ 28.87	1
2	Assistant Director of Nursing	2,123	2,123	48,752	22.96	2
3	Registered Nurses	3,188	3,316	70,672	21.31	3
4	Licensed Practical Nurses	28,731	30,087	536,734	17.84	4
5	CNAs & Orderlies	69,723	71,301	650,688	9.13	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,340	1,400	16,759	11.97	8
9	Activity Director	1,967	2,103	22,123	10.52	9
10	Activity Assistants	2,047	2,288	17,565	7.68	10
11	Social Service Workers	3,961	4,135	50,561	12.23	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,118	14.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,211	19,765	157,029	7.94	15
16	Dishwashers					16
17	Maintenance Workers	3,332	3,484	43,432	12.47	17
18	Housekeepers	14,093	14,282	109,562	7.67	18
19	Laundry	6,130	6,500	53,104	8.17	19
20	Administrator	1,820	1,820	52,631	28.92	20
21	Assistant Administrator	425	425	5,267	12.39	21
22	Other Administrative					22
23	Office Manager	1,685	1,685	19,983	11.86	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	1,947	2,057	24,362	11.84	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	6,337	6,593	105,179	15.95	33
34	TOTAL (lines 1 - 33)	172,220	177,524	\$ 2,074,572 *	\$ 11.69	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 13,200	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,100	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 14,300		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

Toulon Rehabilitation & Health Care Center  
 0046854  
 Period Beginning 01/01/2007  
 Period End 12/31/2007

**Schedule 20A**

**XVIII. Staffing and Salary Costs**  
**Line 32-Other**

	<b># of Hrs. Actually Worked</b>	<b># of Hrs. Paid and Accrued</b>	<b>Reporting Period Total Salaries, Wages</b>	<b>Average Hourly Wage</b>
Alzheimer Coordinator	1,820	1,820	22,405	12.31
Care Plan Coordinator	1,942	2,150	50,503	23.49
Marketing	1,165	1,165	21,291	18.28
Transportation	1,410	1,458	10,980	7.53
<b>Total Line 32-Other</b>	<b>6,337</b>	<b>6,593</b>	<b>105,179</b>	<b>15.95</b>



**Toulon Rehabilitation & Health Care Center**

**0046854**

**Period Beginning 01/01/2007**

**Period End 12/31/2007**

**Schedule 21A**

**XIX. SUPPORT SCHEDULE**

**C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		10,809

**Home Office Allocation**

Pearl & Associates	Legal	41
Addy Bush & Assoc	Legal	21
Registered Agent Solutions	Legal	3
Heyl, Royster, Voelker & Allen	Legal	91
Duane Morris	Legal	142
Ginoli & Co.	Accountants	4,720
RSM McGladrey	Accountants	250
McGladrey & Pullen	Accountants	381
Emdeon Business Services	Computer Services	99
Advanced Answers on Demand	Computer Services	2,673
Access 2 Go	Computer Services	202
Ivans	Computer Services	874
Kemper Technology	Computer Services	419
Administar Federal	Computer Services	52
Logmein	Computer Services	33
E-Health Data Solutions	Computer Services	262
Miscellaneous Vendors	Computer Services	15
CDW	Computer Services	210
Miscellaneous Vendors	Professional Services	66

Total (agree to Schedule V, line 19, column 8)	<u>21,363</u>
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Facility Name & ID Number Toulon Rehabilitation & Health Care Center# 0046854Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$3,750
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,380 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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 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. \$ 9,298
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit still in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees