

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	30,012	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,764	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	136	TOTALS	136	49,776	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			3,931	3,931	8
9	SNF/PED					9
10	ICF	18,472	10,715	241	29,428	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,472	10,715	4,172	33,359	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.02%

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 3,931

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	191,031	23,361	1,038	215,430		215,430	5,929	221,359		1
2	Food Purchase		204,951		204,951		204,951	(10,066)	194,885		2
3	Housekeeping	113,405	29,620		143,025		143,025	44	143,069		3
4	Laundry	66,962	14,480		81,442		81,442	3	81,445		4
5	Heat and Other Utilities			140,088	140,088		140,088	614	140,702		5
6	Maintenance	52,145	18,506	43,186	113,837		113,837	5,150	118,987		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,458	1,458		7
8	TOTAL General Services	423,543	290,918	184,312	898,773		898,773	3,132	901,905		8
	B. Health Care and Programs										
9	Medical Director			21,200	21,200		21,200		21,200		9
10	Nursing and Medical Records	1,451,790	86,754	13,026	1,551,570		1,551,570	8,734	1,560,304		10
10a	Therapy	11,180	119	319,969	331,268		331,268		331,268		10a
11	Activities	47,324	1,414	6,998	55,736		55,736	(507)	55,229		11
12	Social Services	46,331			46,331		46,331		46,331		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							1,797	1,797		15
16	TOTAL Health Care and Programs	1,556,625	88,287	361,193	2,006,105		2,006,105	10,024	2,016,129		16
	C. General Administration										
17	Administrative	26,833		175,000	201,833		201,833	(128,841)	72,992		17
18	Directors Fees										18
19	Professional Services			6,338	6,338		6,338	12,149	18,487		19
20	Dues, Fees, Subscriptions & Promotions			9,165	9,165		9,165	3,197	12,362		20
21	Clerical & General Office Expenses	25,865	7,841	14,758	48,464		48,464	66,470	114,934		21
22	Employee Benefits & Payroll Taxes			337,975	337,975		337,975	1,160	339,135		22
23	Inservice Training & Education			813	813		813	352	1,165		23
24	Travel and Seminar			470	470		470	484	954		24
25	Other Admin. Staff Transportation			18,767	18,767		18,767	7,543	26,310		25
26	Insurance-Prop.Liab.Malpractice			59,845	59,845		59,845	2,090	61,935		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							16,491	16,491		27
28	TOTAL General Administration	52,698	7,841	623,131	683,670		683,670	(18,905)	664,765		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,032,866	387,046	1,168,636	3,588,548		3,588,548	(5,749)	3,582,799		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			259,774	259,774		259,774	26,351	286,125			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			233,505	233,505		233,505	37,971	271,476			32
33	Real Estate Taxes			127,349	127,349		127,349	847	128,196			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,205	25,205		25,205	899	26,104			35
36	Other (specify):*											36
37	TOTAL Ownership			645,833	645,833		645,833	66,068	711,901			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		142,707		142,707		142,707		142,707			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,664	74,664		74,664		74,664			42
43	Other (specify):* Non-allowable Cost	64,622	5,752	122,494	192,868		192,868	(192,868)				43
44	TOTAL Special Cost Centers	64,622	148,459	197,158	410,239		410,239	(192,868)	217,371			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,097,488	535,505	2,011,627	4,644,620		4,644,620	(132,549)	4,512,071			45

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

VI. ADJUSTMENT DETAIL

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

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

		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	(10,163)	2		4
5	Telephone, TV & Radio in Resident Rooms	(337)	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	(3,784)	30		9
10	Interest and Other Investment Income	(26)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(640)	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	(5,256)	43		18
19	Entertainment				19
20	Contributions	(25)	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	(78,133)	43		24
25	Fund Raising, Advertising and Promotional	(23,895)	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	(87,932)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (210,191)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	77,642	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 77,642		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (132,549)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (14,182)	43	1
2	X-Rays-Part A	(4,351)	43	2
3	Disallowed Special Events	(312)	43	3
4	Resident Flower	(1,115)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(412)	21	5
6	Offset Chamber of Commerce Dues	(874)	20	6
7	Disallowed Marketing Salaries	(64,622)	43	7
8	Offset Miscellaneous Nursing Supplies Revenue	(1,557)	10	8
9	Offset Transportation Revenue	(507)	11	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
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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	Total	(87,932)		49

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%	\$ 5,929	\$ 5,929	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	97	97	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	44	44	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	614	614	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,624	3,624	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,458	1,458	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10,291	10,291	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,797	1,797	10
11	V	17 Administrative	175,000	Petersen Health Care, Inc.	100.00%	46,159	(128,841)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,210	5,210	12
13	V							13
14	Total		\$ 175,000			\$ 75,226	\$ * (99,774)	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%	\$ 1,607	\$ 1,607
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	57,925	57,925
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	352	352
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	353	353
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,561	4,561
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	278	278
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	16,491	16,491
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	6,311	6,311
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,439	4,439
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	847	847
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0	
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	722	722
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		\$			\$ 93,886	\$ * 93,886

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

Facility Name & ID Number Toulon Rehabilitation & Health Care Center# 0046854Report Period Beginning: 1/1/2008Ending: 12/31/2008

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	\$	15	
16	V	2 Food		Petersen Health Care II, Inc.	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care II, Inc.	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care II, Inc.	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care II, Inc.	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care II, Inc.	100.00%	1,526	1,526	20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care II, Inc.	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		23	
24	V	17 Administrative		Petersen Health Care II, Inc.	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Care II, Inc.	100.00%	6,939	6,939	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	2,464	2,464	26	
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	8,957	8,957	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	1,160	1,160	28	
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	131	131	30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	2,982	2,982	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	1,812	1,812	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care II, Inc.	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care II, Inc.	100.00%	23,824	23,824	34	
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	33,558	33,558	35	
36	V	33 Real Estate Taxes		Petersen Health Care II, Inc.	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care II, Inc.	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care II, Inc.	100.00%	177	177	38	
39	Total		\$			\$ 83,530	\$ *	83,530	39

* 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: 1/1/2008 Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	1,782,515	1.39	2.31	Salary	\$ 46,159	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	\$ 46,159		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:

1/1/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	33,359	\$ 5,929	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	33,359	97	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	33,359	44	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	33,359	3	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	33,359	614	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	33,359	3,624	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	33,359	1,458	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	33,359	10,291	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	33,359	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	33,359	1,797	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	33,359	46,159	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	33,359	5,210	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	33,359	1,607	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	33,359	57,925	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	33,359	352	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	33,359	353	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	33,359	4,561	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	33,359	278	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	33,359	16,491	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	33,359	6,311	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	33,359	4,439	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	33,359	847	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	33,359	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	33,359	722	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 169,112	25

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning:

1/1/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care 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	331,413	13	\$	33,359	\$	1
2	2	Food	Resident Days	331,413	13		33,359		2
3	3	Housekeeping	Resident Days	331,413	13		33,359		3
4	4	Laundry	Resident Days	331,413	13		33,359		4
5	5	Utilities	Resident Days	331,413	13		33,359		5
6	6	Maintenance	Resident Days	331,413	13	15,163	33,359	1,526	6
7	7	Mgmt. Allocation of Benefits	Resident Days	331,413	13		33,359		7
8	10	Nursing and Medical Records	Resident Days	331,413	13		33,359		8
9	15	Mgmt. Allocation of Benefits	Resident Days	331,413	13		33,359		9
10	17	Administrative	Resident Days	331,413	13		33,359		10
11	19	Professional Services	Resident Days	331,413	13	68,939	33,359	6,939	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	331,413	13	24,482	33,359	2,464	12
13	21	Clerical and General Office	Resident Days	331,413	13	88,982	33,359	8,957	13
14	22	Employee Benefits & Payroll	Resident Days	331,413	13	11,527	33,359	1,160	14
15	23	Inservice Training & Education	Resident Days	331,413	13		33,359		15
16	24	Travel and Seminar	Resident Days	331,413	13	1,299	33,359	131	16
17	25	Other Admin. Staff Transport.	Resident Days	331,413	13	29,621	33,359	2,982	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	331,413	13	18,001	33,359	1,812	18
19	27	Mgmt. Allocation of Benefits	Resident Days	331,413	13		33,359		19
20	30	Depreciation	Resident Days	331,413	13	236,686	33,359	23,824	20
21	32	Interest	Resident Days	331,413	13	333,393	33,359	33,558	21
22	33	Real Estate Taxes	Resident Days	331,413	13		33,359		22
23	34	Rent-Facility and Grounds	Resident Days	331,413	13		33,359		23
24	35	Rent-Equipment & Vehicles	Resident Days	331,413	13	1,756	33,359	177	24
25	TOTALS					\$ 829,849	\$	\$ 83,530	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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			
A. Directly Facility Related																	
Long-Term																	
1	US Bank		X	Mortgage	Varies	12/9/04	\$ 3,660,000	\$ 3,281,338	12/31/11	Varies	\$ 232,415	1					
2												2					
3							Interest Income Offset				(26)	3					
4							Home Office Allocation-PHC				4,439	4					
5							Home Office Allocation-PHC II				33,558	5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$ 3,660,000	\$ 3,281,338			\$ 270,386	9					
B. Non-Facility Related*																	
10												10					
11							Amortization of Mortgage Costs				1,090	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 1,090	14					
15	TOTALS (line 9+line14)						\$ 3,660,000	\$ 3,281,338			\$ 271,476	15					

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

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

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

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2007 report.		\$	124,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	123,349	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(651)	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	128,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			847	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	128,196	7

Home Office Allocation

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003		8
	2004		9
	2005	116,093	10
	2006	120,024	11
	2007	123,349	12

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>04-19-401-037</u>	<u>Long-Term Care Facility</u>	\$ <u>2,325.78</u>	\$ <u>2,325.78</u>
2. <u>04-19-401-039</u>	<u>Long-Term Care Facility</u>	\$ <u>121,023.70</u>	\$ <u>121,023.70</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>123,349.48</u>	\$ <u>123,349.48</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

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:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	136	2005	1977	\$ 3,371,115	\$	30	\$ 112,370	\$ 112,370	\$ 449,481
5									
6									
7									
8									
Improvement Type**									
9	Parking lot/sidewalks		2005	621,663		15	41,444	41,444	165,776
10	New Carpet		2005	9,194		10	919	919	3,140
11	Fire Suppression System		2005	9,750		10	975	975	3,006
12	Sidewalks		2006	10,292		15	686	686	1,829
13	Water Heater		2007	5,159		10	516	516	774
14	Fire/Door Alarms		2007	2,090		10	209	209	314
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28	Building Booked				112,370			(112,370)	
29	Building Improvement Booked				44,500			(44,500)	
30									
31									
32	2008-Home Office Allocation-Land Improvements			1,159			75	75	
33	2008-Home Office Allocation-Building Improvements			17,321			415	415	
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)	\$ 4,047,743	\$ 156,870		\$ 157,609	\$ 739	\$ 624,320	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	\$ 946,021	\$ 100,721	\$ 94,602	\$ (6,119)	7-10 yrs.	\$ 369,001	71
72	Current Year Purchases	5,589	167	279	112	10 yrs.	279	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			30,135	30,135			74
75	TOTALS	\$ 951,610	\$ 100,888	\$ 125,016	\$ 24,128		\$ 369,280	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	\$ 2,016	\$ 3,500	\$ 1,484	5	\$ 14,000	76
77										77
78										78
79										79
80	TOTALS			\$ 17,500	\$ 2,016	\$ 3,500	\$ 1,484		\$ 14,000	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)	\$ 5,166,853	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 259,774	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 286,125	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 26,351	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,007,600	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

**

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 8,376 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Ford E250 Van	\$ 1,477	\$ 17,728	17
18					18
19					19
20					20
21	TOTAL		\$ 1,477	\$ 17,728	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.	<u>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</u>	\$ _____

* 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 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 4,309
Dishwasher	708
Copier	2,460
Home Office Allocation	899
	<u>8,376</u>
	<u>8,376</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	9,334	\$ 140,003	\$	9,334	\$ 140,003	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,045	15,669		1,045	15,669	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(1,2,3)	964 hrs	11,180	10,953	164,297	119	11,917	175,596	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				142,707		142,707	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 11,180	21,332	\$ 319,969	\$ 142,826	22,296	\$ 473,975	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: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,417,389	\$ 1,417,389	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	1,102,867	1,102,867	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,638	33,638	6
7	Other Prepaid Expenses	16,910	16,910	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u> </u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,570,804	\$ 2,570,804	10
	B. Long-Term Assets			
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	3,388,436	14
15	Leasehold Improvements, at Historical Cost	16,443	659,307	15
16	Equipment, at Historical Cost	969,110	969,110	16
17	Accumulated Depreciation (book methods)	(1,027,653)	(1,007,600)	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>	3,270	3,270	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,381,012	\$ 4,429,295	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,951,816	\$ 7,000,099	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 853,370	\$ 853,370	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	131,832	131,832	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,636	5,636	31
32	Accrued Real Estate Taxes(Sch.IX-B)	128,000	128,000	32
33	Accrued Interest Payable	18,304	18,304	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	39,285	39,285	36
37	<u> </u>			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,176,427	\$ 1,176,427	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,281,338	3,281,338	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u> </u>			43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,281,338	\$ 3,281,338	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,457,765	\$ 4,457,765	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,494,051	\$ 2,542,334	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,951,816	\$ 7,000,099	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,156,915	1
2	Restatements (describe):		2
3	Rounding	(5)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,156,910	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	337,141	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)	\$ 337,141	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,494,051	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,951,870	1
2	Discounts and Allowances for all Levels	268,018	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,219,888	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	501,864	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 501,864	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,163	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	226,527	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,550	20
21	Other Medical Services	6,267	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 257,507	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,969	28
28a	Transportation Revenue	507	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,476	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,981,761	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	898,773	31
32	Health Care	2,006,105	32
33	General Administration	683,670	33
	B. Capital Expense		
34	Ownership	645,833	34
	C. Ancillary Expense		
35	Special Cost Centers	335,575	35
36	Provider Participation Fee	74,664	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,644,620	40
41	Income before Income Taxes (line 30 minus line 40)**	337,141	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 337,141	43

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

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

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

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

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 60,592	\$ 29.13	1
2	Assistant Director of Nursing	1,741	1,741	41,686	23.94	2
3	Registered Nurses	2,339	2,467	54,411	22.06	3
4	Licensed Practical Nurses	27,697	29,116	519,189	17.83	4
5	CNAs & Orderlies	70,057	71,943	675,610	9.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	895	964	11,180	11.60	8
9	Activity Director	2,005	2,176	23,777	10.93	9
10	Activity Assistants	1,782	1,782	13,009	7.30	10
11	Social Service Workers	3,675	3,829	46,331	12.10	11
12	Dietician					12
13	Food Service Supervisor	2,313	2,313	32,123	13.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,509	19,045	158,908	8.34	15
16	Dishwashers					16
17	Maintenance Workers	3,982	4,143	52,145	12.59	17
18	Housekeepers	13,313	13,423	113,405	8.45	18
19	Laundry	7,265	7,641	66,962	8.76	19
20	Administrator	693	693	26,833	38.72	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,173	2,197	25,865	11.77	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	1,941	2,215	25,922	11.70	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. PG20A</u>	7,911	8,244	149,540	18.14	33
34	TOTAL (lines 1 - 33)	170,371	176,012	\$ 2,097,488 *	\$ 11.92	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	18 hrs.	\$ 1,038	1(3)	35
36	Medical Director	Monthly	21,200	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,230	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)		\$ 23,468		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 1/1/2008

Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Alzheimer Coordinator	2,080	2,080	27,429	13.19
Care Plan Coordinator	1,900	2,112	46,951	22.23
Marketing	2,592	2,713	64,622	23.82
Transportation	1,339	1,339	10,538	7.87
TOTAL (lines 1 - 35)	7,911	8,244	149,540	

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		
Susan VanDeRostyne	Administrator	0	\$ 26,833	Workers' Compensation Insurance	\$ 79,286	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	38,145	Advertising: Employee Recruitment	1,072		
				FICA Taxes	156,766	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	59,956	Patient Background Checks	155 1,550		
				Employee Meals		Miscellaneous Licenses & Permits	482		
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	1,086		
				Employee Relations	3,613	IHCA Dues	3,980		
				Employee Retirement	1,369	Home Office Allocation	4,071		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 26,833	TOTAL (agree to Schedule V, line 22, col.8)		\$ 339,135	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,362
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 175,000				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 175,000	N/A			In-State Travel		
C. Professional Services				TOTAL			Seminar Expense		470
Vendor/Payee	Type		Amount				Home Office Allocation	484	
E-Health Data Solutions	Computer Services		\$ 3,240				Entertainment Expense (agree to Sch. V, line 24, col. 8)		
Mediacom	Computer Services		1,498				TOTAL	\$ 954	
LTC Solutions	Computer Services		1,600						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 6,338						

* Attach copy of IMRF notifications

**See instructions.

Toulon Rehabilitation & Health Care Center

0046854

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,338

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	189
GoffWilson, P.A.	Legal	632
U.S. Bank	Legal	1,103
Ginoli & Company	Accountants	5,558
RSM McGladrey	Accountants	14
U.S. Bank	Accountants	677
Miscellaneous Vendors	Computer Services	74
Emdeon Business Services	Computer Services	102
Advanced Answers on Demand	Computer Services	1,197
Access 2 Go	Computer Services	353
Ivans	Computer Services	983
Kemper Technology	Computer Services	648
VisionShare	Computer Services	69
Logmein	Computer Services	50
Comm Net Communiations	Computer Services	18
Charter Communications	Computer Services	15
Advanced System Designs	Computer Services	23
Consolidated Communications	Computer Services	14
CDW	Computer Services	337
Miscellaneous Vendors	Miscellaneous	93

Total (agree to Schedule V, line 19, column 8)	<u><u>18,487</u></u>
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Toulon Rehabilitation & Health Care Center

0046854

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan VanDeRoystne	Administrator	0	26,833
		Total	<u>26,833</u>

Facility Name & ID Number Toulon Rehabilitation & Health Care Center# 0046854Report Period Beginning: 1/1/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 3,980 -IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 17,706 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 74,664
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. \$ 10,163
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees