

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF			3,722	3,722	8
9	SNF/PED					9
10	ICF	17,353	10,938	1,880	30,171	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,353	10,938	5,602	33,893	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 68.28%

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 3,722

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: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Toulon Rehabilitation & Health Care Center # 0046854 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	191,205	23,758		214,963		214,963	5,927	220,890		1
2	Food Purchase		212,700		212,700		212,700	(8,072)	204,628		2
3	Housekeeping	112,250	34,843		147,093		147,093	56	147,149		3
4	Laundry	72,343	18,902		91,245		91,245		91,245		4
5	Heat and Other Utilities			154,131	154,131		154,131	585	154,716		5
6	Maintenance	53,361	16,162	38,744	108,267		108,267	2,934	111,201		6
7	Other (specify):* Home Off. Ben. All.							1,070	1,070		7
8	TOTAL General Services	429,159	306,365	192,875	928,399		928,399	2,500	930,899		8
	B. Health Care and Programs										
9	Medical Director			19,700	19,700		19,700		19,700		9
10	Nursing and Medical Records	1,590,316	124,834	2,244	1,717,394		1,717,394	2,149	1,719,543		10
10a	Therapy	4,676		379,433	384,109		384,109		384,109		10a
11	Activities	27,785	404	7,103	35,292		35,292	(1,889)	33,403		11
12	Social Services	56,051			56,051		56,051		56,051		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							442	442		15
16	TOTAL Health Care and Programs	1,678,828	125,238	408,480	2,212,546		2,212,546	702	2,213,248		16
	C. General Administration										
17	Administrative	23,400		272,000	295,400		295,400	(201,647)	93,753		17
18	Directors Fees										18
19	Professional Services			29,367	29,367		29,367	22,324	51,691		19
20	Dues, Fees, Subscriptions & Promotions			6,678	6,678		6,678	3,752	10,430		20
21	Clerical & General Office Expenses	26,310	8,066	10,485	44,861		44,861	70,853	115,714		21
22	Employee Benefits & Payroll Taxes			318,909	318,909		318,909	8,700	327,609		22
23	Inservice Training & Education							865	865		23
24	Travel and Seminar			500	500		500	190	690		24
25	Other Admin. Staff Transportation			11,196	11,196		11,196	7,340	18,536		25
26	Insurance-Prop.Liab.Malpractice			212,237	212,237		212,237	1,236	213,473		26
27	Other (specify):* Home Off. Ben. All.							16,223	16,223		27
28	TOTAL General Administration	49,710	8,066	861,372	919,148		919,148	(70,164)	848,984		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,157,697	439,669	1,462,727	4,060,093		4,060,093	(66,962)	3,993,131		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: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			261,161	261,161		261,161	30,920	292,081			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			228,775	228,775		228,775	36,077	264,852			32
33	Real Estate Taxes			126,635	126,635		126,635	751	127,386			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,331	13,331		13,331	721	14,052			35
36	Other (specify):*											36
37	TOTAL Ownership			629,902	629,902		629,902	68,469	698,371			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,220		137,220		137,220		137,220			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	31,701	4,017	70,841	106,559		106,559	(106,559)				43
44	TOTAL Special Cost Centers	31,701	141,237	145,301	318,239		318,239	(106,559)	211,680			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,189,398	580,906	2,237,930	5,008,234		5,008,234	(105,052)	4,903,182			45

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

Toulon Rehabilitation & Health Care Center

ID# 0046854

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (28,379)	43	1
2	X-Rays-Part A	(3,613)	43	2
3	Disallowed Special Events	(1,035)	43	3
4	Resident Flower	(1,315)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(394)	21	5
6	Offset Chamber of Commerce Dues	(275)	20	6
7	Disallowed Marketing Salaries	(31,701)	43	7
8	Offset Miscellaneous Nursing Supplies Revenue	(1,438)	10	8
9	Offset Transportation Revenue	(1,889)	11	9
10	Pet Expense	(1,200)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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40				40
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(71,239)		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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 5,927	\$ 5,927	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	133	133	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	56	56	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	585	585	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,871	2,871	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,070	1,070	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,587	3,587	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%	442	442	10
11	V	17 Administrative	272,000	Petersen Health Care, Inc.	100.00%	70,353	(201,647)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	8,310	8,310	12
13	V							13
14	Total		\$ 272,000			\$ 93,334	\$ * (178,666)	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%	\$ 2,316	\$	2,316	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	60,438		60,438	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	617		617	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	190		190	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,978		2,978	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,236		1,236	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	16,223		16,223	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	4,885		4,885	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	7,513		7,513	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	751		751	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	718		718	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 97,865	\$ *	97,865	39

* 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: 1/1/2009Ending: 12/31/2009

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%	63		63 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%	14,014		14,014 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care II, Inc.	100.00%	1,711		1,711 26
27	V	21 Clerical and General Office		Petersen Health Care II, Inc.	100.00%	10,809		10,809 27
28	V	22 Employee Benefits & Payroll		Petersen Health Care II, Inc.	100.00%	8,700		8,700 28
29	V	23 Inservice Training & Education		Petersen Health Care II, Inc.	100.00%	248		248 29
30	V	24 Travel and Seminar		Petersen Health Care II, Inc.	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Care II, Inc.	100.00%	4,362		4,362 31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care II, Inc.	100.00%	0		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%	29,504		29,504 34
35	V	32 Interest		Petersen Health Care II, Inc.	100.00%	29,893		29,893 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%	3		3 38
39	Total		\$			\$ 99,307	\$ *	99,307 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: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	155,260	1.32	2.20	Salary	\$ 3,853	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	\$ 3,853		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:

1/1/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,493,044	75	\$ 261,102	\$ 259,584	33,893	\$ 5,927	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	33,893	133	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	33,893	56	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	33,893	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	33,893	585	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	33,893	2,871	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	33,893	1,070	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	33,893	3,587	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	33,893	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	33,893	442	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	33,893	70,353	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	33,893	8,310	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	33,893	2,316	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	33,893	60,438	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	33,893	617	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	33,893	190	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	33,893	2,978	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	33,893	1,236	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	33,893	16,223	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	33,893	4,885	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	33,893	7,513	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	33,893	751	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	33,893	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	33,893	718	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 191,199	25

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care 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	336,837	13	\$	\$	33,893	\$	1
2	2	Food	Resident Days	336,837	13			33,893		2
3	3	Housekeeping	Resident Days	336,837	13			33,893		3
4	4	Laundry	Resident Days	336,837	13			33,893		4
5	5	Utilities	Resident Days	336,837	13			33,893		5
6	6	Maintenance	Resident Days	336,837	13	628		33,893	63	6
7	7	Mgmt. Allocation of Benefits	Resident Days	336,837	13			33,893		7
8	10	Nursing and Medical Records	Resident Days	336,837	13			33,893		8
9	15	Mgmt. Allocation of Benefits	Resident Days	336,837	13			33,893		9
10	17	Administrative	Resident Days	336,837	13			33,893		10
11	19	Professional Services	Resident Days	336,837	13	139,269		33,893	14,014	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	336,837	13	17,001		33,893	1,711	12
13	21	Clerical and General Office	Resident Days	336,837	13	107,426		33,893	10,809	13
14	22	Employee Benefits & Payroll	Resident Days	336,837	13	86,458		33,893	8,700	14
15	23	Inservice Training & Education	Resident Days	336,837	13	2,464		33,893	248	15
16	24	Travel and Seminar	Resident Days	336,837	13			33,893		16
17	25	Other Admin. Staff Transport.	Resident Days	336,837	13	43,354		33,893	4,362	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	336,837	13			33,893		18
19	27	Mgmt. Allocation of Benefits	Resident Days	336,837	13			33,893		19
20	30	Depreciation	Resident Days	336,837	13	293,215		33,893	29,504	20
21	32	Interest	Resident Days	336,837	13	297,084		33,893	29,893	21
22	33	Real Estate Taxes	Resident Days	336,837	13			33,893		22
23	34	Rent-Facility and Grounds	Resident Days	336,837	13			33,893		23
24	35	Rent-Equipment & Vehicles	Resident Days	336,837	13	26		33,893	3	24
25	TOTALS					\$ 986,925	\$		\$ 99,307	25

Facility Name & ID Number

Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	US Bank		X	Mortgage	Varies	12/9/04	\$ 3,660,000	\$ 3,166,895	12/31/11	Varies	\$ 227,685	1							
2												2							
3							Interest Income Offset				(1,329)	3							
4							Home Office Allocation-PHC				7,513	4							
5							Home Office Allocation-PHC II				29,893	5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 3,660,000	\$ 3,166,895			\$ 263,762	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	\$ 3,166,895			\$ 264,852	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.)

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	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	\$ 561,851
5									
6									
7									
8									
Improvement Type**									
9	Parking lot/sidewalks		2005	621,663		15	41,444	41,444	207,220
10	New Carpet		2005	9,194		10	919	919	4,059
11	Fire Suppression System		2005	9,750		10	975	975	3,981
12	Sidewalks		2006	10,292		15	686	686	2,515
13	Water Heater		2007	5,159		10	516	516	1,290
14	Fire/Door Alarms		2007	2,090		10	209	209	523
15	Water Heater		2009	3,900		5	390	390	390
16	Water Heater		2009	6,200		5	620	620	620
17	Remodeling of A,B,C wings		2009	12,950		15	432	432	432
18									
19									
20									
21									
22									
23									
24									
25									
26									
27	Land Improvements Booked				42,130			(42,130)	
28	Building Booked				112,370			(112,370)	
29	Building Improvement Booked				3,997			(3,997)	
30									
31									
32	2009-Home Office Allocation-Land Improvements			1,115			70	70	
33	2009-Home Office Allocation-Building Improvements			16,662			400	400	
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)	\$ 4,070,090	\$ 158,497		\$ 159,031	\$ 534	\$ 782,881	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	\$ 951,610	\$ 100,648	\$ 95,161	\$ (5,487)	7-10 yrs.	\$ 464,441	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			34,389	34,389			74
75	TOTALS	\$ 951,610	\$ 100,648	\$ 129,550	\$ 28,902		\$ 464,441	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	\$ 17,500	76
77										77
78										78
79										79
80	TOTALS			\$ 17,500	\$ 2,016	\$ 3,500	\$ 1,484		\$ 17,500	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)	\$ 5,189,200	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 261,161	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 292,081	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 30,920	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,264,822	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: \$ 7,189 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	\$ 572	\$ 6,863	17
18					18
19					19
20					20
21	TOTAL		\$ 572.00	\$ 6,863	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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 **1/1/2009**
Period End **12/31/2009**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	4,321
Dishwasher		708
Copier		1,439
Home Office Allocation		721
		<u>7,189</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?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	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)	369 hrs	\$ 4,676	10,952	\$ 164,284		11,321	\$ 168,960	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,035	15,522		1,035	15,522	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		13,293	199,393		13,293	199,393	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				137,220		137,220	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>					234			234	13
14	TOTAL			\$ 4,676	25,280	\$ 379,433	\$ 137,220	25,649	\$ 521,329	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# 0046854Report Period Beginning: 1/1/2009Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,866,004	\$ 1,866,004	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	978,682	978,682	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	67,795	67,795	6
7	Other Prepaid Expenses	19,674	19,674	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,932,155	\$ 2,932,155	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	3,387,777	14
15	Leasehold Improvements, at Historical Cost	39,493	682,313	15
16	Equipment, at Historical Cost	969,110	969,110	16
17	Accumulated Depreciation (book methods)	(1,288,815)	(1,264,822)	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 (spe <u>Goodwill</u>)	266,772	266,772	22
23	Other(specify): <u>Loan Costs</u>	2,180	2,180	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,141,810	\$ 4,193,330	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,073,965	\$ 7,125,485	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 717,152	\$ 717,152	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	134,639	134,639	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,004	4,004	31
32	Accrued Real Estate Taxes(Sch.IX-B)	129,200	129,200	32
33	Accrued Interest Payable	19,944	19,944	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	98,888	98,888	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,103,827	\$ 1,103,827	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,166,895	3,166,895	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,166,895	\$ 3,166,895	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,270,722	\$ 4,270,722	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,803,243	\$ 2,854,763	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,073,965	\$ 7,125,485	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,494,051	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,494,052	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	309,191	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)	\$ 309,191	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)	\$ 2,803,243	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,511,924	1
2	Discounts and Allowances for all Levels	(136,761)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,375,163	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	601,270	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 601,270	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	8,205	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	299,516	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	20,545	20
21	Other Medical Services	7,676	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 335,942	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,329	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,329	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	1,832	28
28a	Transportation Revenue	1,889	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,721	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,317,425	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	928,399	31
32	Health Care	2,212,546	32
33	General Administration	919,148	33
B. Capital Expense			
34	Ownership	629,902	34
C. Ancillary Expense			
35	Special Cost Centers	243,779	35
36	Provider Participation Fee	74,460	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,008,234	40
41	Income before Income Taxes (line 30 minus line 40)**	309,191	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 309,191	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: **1/1/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,167	2,167	\$ 63,684	\$ 29.39	1
2	Assistant Director of Nursing	1,870	1,910	46,212	24.19	2
3	Registered Nurses	4,508	4,672	107,064	22.92	3
4	Licensed Practical Nurses	27,307	28,632	533,930	18.65	4
5	CNAs & Orderlies	75,087	77,221	731,736	9.48	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	365	369	4,676	12.67	8
9	Activity Director	7	7	102	14.57	9
10	Activity Assistants	1,806	1,849	15,326	8.29	10
11	Social Service Workers	3920	4,168	56,051	13.45	11
12	Dietician					12
13	Food Service Supervisor	3,640	3,640	45,635	12.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,664	17,311	145,570	8.41	15
16	Dishwashers					16
17	Maintenance Workers	3,926	4,131	53,361	12.92	17
18	Housekeepers	12,911	13,035	112,250	8.61	18
19	Laundry	8,013	8,452	72,343	8.56	19
20	Administrator	2,080	2,080	89,900	43.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,030	2,111	26,310	12.46	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	1,983	2,187	27,321	12.49	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. PG20A</u>	7,534	7,860	124,427	15.83	33
34	TOTAL (lines 1 - 33)	175,818	181,802	\$ 2,255,898 *	\$ 12.41	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 19,700	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,270	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)	\$ 20,970		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 1/1/2009

Period End 12/31/2009

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	27,229	13.09
Care Plan Coordinator	1,909	2,144	53,140	24.79
Marketing	2,080	2,080	31,701	15.24
Transportation	1,465	1,556	12,357	7.94
TOTAL (lines 1 - 35)	7,534	7,860	124,427	

Toulon Rehabilitation & Health Care Center

0046854

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		29,367

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	53
GoffWilson, P.A.	Legal	75
Jackson Lewis	Legal	589
Peter Gartelos	Legal	57
Misc.	Legal	51
Ginoli & Company	Accountants	3,932
Miscellaneous Vendors	Computer Services	55
Emdeon Business Services	Computer Services	25
Advanced Answers on Demand	Computer Services	3,193
Access 2 Go	Computer Services	307
Ivans	Computer Services	190
Kemper Technology	Computer Services	868
VisionShare	Computer Services	270
MediFax	Computer Services	110
LogmeIn	Computer Services	48
Charter Communications	Computer Services	2
CDW	Computer Services	484
Simple LTC	Computer Services	737
Polaris Group	Other Professional Services	10,582
Donna Howard & Assoc.	Other Professional Services	181
Miscellaneous Vendors	Miscellaneous	515
Total (agree to Schedule V, line 19, column 8)		<u>51,691</u>

Toulon Rehabilitation & Health Care Center

0046854

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Heyl, Royster, Voelker, & Allen	2,621.28	100%	2,621
Heyl, Royster, Voelker, & Allen	6,047.04	100%	6,047
Heyl, Royster, Voelker, & Allen	1,944.49	100%	1,944
Kingery, Duree Wakeman & Ryan	878.93	100%	879
Kingery, Duree Wakeman & Ryan	176.58	100%	177
Heyl, Royster, Voelker, & Allen	4,881.03	100%	4,881
Heyl, Royster, Voelker, & Allen	140.00	100%	140
Heyl, Royster, Voelker, & Allen	2,766.40	100%	2,766
Heyl, Royster, Voelker, & Allen	3,685.51	100%	3,685

Home Office Allocation

Heyl, Royster, Voelker, and Allen	2,414.77	2.19%	53
GoffWilson	3,425.00	2.19%	75
Jackson Lewis	27,043.20	2.19%	589
Peter Gartelos	2,612.50	2.19%	57
Miscellaneous Vendors	2,327.62	2.19%	51

Total Legal Fees

23,966

Facility Name & ID Number Toulon Rehabilitation & Health Care Center

0046854

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 1,500 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 11,967 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. \$ 74,460
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. \$ 8,205
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.