

Robings Manor Rehab & Health Care

0026716

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 4,243
Dishwasher	806
Nursing Equipment	3,482
Home Office Allocation	661
	<u>9,192</u>

Facility Name & ID Number Robings Manor Rehab & Health Care

0026716 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>32</u>	Skilled (SNF)	<u>32</u>	<u>11,680</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>43</u>	Intermediate (ICF)	<u>43</u>	<u>15,695</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>75</u>	TOTALS	<u>75</u>	<u>27,375</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF			<u>1,940</u>	<u>1,940</u>	8
9	SNF/PED					9
10	ICF	<u>18,179</u>	<u>4,962</u>		<u>23,141</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18,179</u>	<u>4,962</u>	<u>1,940</u>	<u>25,081</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.62%

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)

Independent Living

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 01/01/1977

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

K. Was the facility certified for Medicare during the reporting year?
 YES NO If YES, enter number of beds certified 25 and days of care provided 1,940

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

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	101,730	15,609	885	118,224		118,224	(7,761)	110,463		1
2	Food Purchase		125,120		125,120		125,120	(12,134)	112,986		2
3	Housekeeping	71,871	15,131		87,002		87,002	(7,232)	79,770		3
4	Laundry	44,121	15,388	54	59,563		59,563	(4,967)	54,596		4
5	Heat and Other Utilities			80,422	80,422		80,422	(6,349)	74,073		5
6	Maintenance	26,265	9,926	34,444	70,635		70,635	(2,967)	67,668		6
7	Other (specify):* Home Off. Ben. All.							958	958		7
8	TOTAL General Services	243,987	181,174	115,805	540,966		540,966	(40,452)	500,514		8
	B. Health Care and Programs										
9	Medical Director			13,750	13,750		13,750		13,750		9
10	Nursing and Medical Records	728,060	33,240	3,593	764,893		764,893	4,354	769,247		10
10a	Therapy		604	228,963	229,567		229,567	(135)	229,432		10a
11	Activities	21,975	1,223	400	23,598		23,598		23,598		11
12	Social Services	21,754	9		21,763		21,763		21,763		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,234	1,234		15
16	TOTAL Health Care and Programs	771,789	35,076	246,706	1,053,571		1,053,571	5,453	1,059,024		16
	C. General Administration										
17	Administrative	84,771			84,771		84,771	15,624	100,395		17
18	Directors Fees										18
19	Professional Services			13,251	13,251		13,251	4,241	17,492		19
20	Dues, Fees, Subscriptions & Promotions			11,692	11,692		11,692	862	12,554		20
21	Clerical & General Office Expenses	31,718	5,662	9,736	47,116		47,116	34,900	82,016		21
22	Employee Benefits & Payroll Taxes			146,885	146,885		146,885		146,885		22
23	Inservice Training & Education			75	75		75	409	484		23
24	Travel and Seminar							651	651		24
25	Other Admin. Staff Transportation			9,874	9,874		9,874	2,359	12,233		25
26	Insurance-Prop.Liab.Malpractice			20,116	20,116		20,116	961	21,077		26
27	Other (specify):* Home Off. Ben. All.							10,172	10,172		27
28	TOTAL General Administration	116,489	5,662	211,629	333,780		333,780	70,179	403,959		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,132,265	221,912	574,140	1,928,317		1,928,317	35,180	1,963,497		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 Robings Manor Rehab & Health Care #0026716 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			107,077	107,077		107,077	(35,479)	71,598			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			278,303	278,303		278,303	4,330	282,633			32
33	Real Estate Taxes			13,864	13,864		13,864	821	14,685			33
34	Rent-Facility & Grounds							50	50			34
35	Rent-Equipment & Vehicles			8,531	8,531		8,531	661	9,192			35
36	Other (specify):*											36
37	TOTAL Ownership			407,775	407,775		407,775	(29,617)	378,158			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		71,229		71,229		71,229		71,229			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,063	41,063		41,063		41,063			42
43	Other (specify):* Non-allowable Cost	31,911	1,398	30,163	63,472		63,472	(63,472)				43
44	TOTAL Special Cost Centers	31,911	72,627	71,226	175,764		175,764	(63,472)	112,292			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,164,176	294,539	1,053,141	2,511,856		2,511,856	(57,909)	2,453,947			45

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

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,772)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,621)	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	(37,970)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(252)	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	(13,000)	43		18
19	Entertainment				19
20	Contributions	(36)	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	2,793	43		24
25	Fund Raising, Advertising and Promotional	(40,404)	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	(55,133)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (150,395)		\$	30

BHF USE ONLY					
48	49	50	51	52	

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	92,486	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 92,486		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (57,909)		37

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

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

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

Robings Manor Rehab & Health Care

ID# 0026716

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (2,796)	43	1
2	X-Rays-Part A	(688)	43	2
3	Disallowed Special Events	(3,350)	43	3
4	Resident Flowers	(1,118)	43	4
5	Disallowed Dues	(57)	20	5
6	Independent Living Dietary Cost Offset	(9,860)	1	6
7	Independent Living Food Cost Offset	(10,435)	2	7
8	Independent Living Housekeeping Cost Offset	(7,256)	3	8
9	Independent Living Laundry Cost Offset	(4,968)	4	9
10	Independent Living Utilities Cost Offset	(6,707)	5	10
11	Independent Living Maintenance Cost Offset	(5,891)	6	11
12	Offset of Miscellaneous Income	(2,007)	10,10A,21	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(55,133)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Robings Manor Rehab & Health Care# 0026716

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(9,860)	2,099	0	0	0	0	0	0	0	0	0	(7,761)	1
2	Food Purchase	(12,207)	73	0	0	0	0	0	0	0	0	0	(12,134)	2
3	Housekeeping	(7,256)	24	0	0	0	0	0	0	0	0	0	(7,232)	3
4	Laundry	(4,968)	1	0	0	0	0	0	0	0	0	0	(4,967)	4
5	Heat and Other Utilities	(6,707)	358	0	0	0	0	0	0	0	0	0	(6,349)	5
6	Maintenance	(5,891)	2,924	0	0	0	0	0	0	0	0	0	(2,967)	6
7	Other (specify):*	0	958	0	0	0	0	0	0	0	0	0	958	7
8	TOTAL General Services	(46,889)	6,437	0	0	0	0	0	0	0	0	0	(40,452)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,550	0	0	0	0	0	0	0	0	0	5,550	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	1,234	0	0	0	0	0	0	0	0	0	1,234	15
16	TOTAL Health Care and Programs	0	6,784	0	0	0	0	0	0	0	0	0	6,784	16
	C. General Administration													
17	Administrative	0	15,624	0	0	0	0	0	0	0	0	0	15,624	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,241	0	0	0	0	0	0	0	0	0	4,241	19
20	Fees, Subscriptions & Promotions	(57)	0	919	0	0	0	0	0	0	0	0	862	20
21	Clerical & General Office Expenses	0	0	35,576	0	0	0	0	0	0	0	0	35,576	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	409	0	0	0	0	0	0	0	0	409	23
24	Travel and Seminar	0	0	651	0	0	0	0	0	0	0	0	651	24
25	Other Admin. Staff Transportation	0	0	2,359	0	0	0	0	0	0	0	0	2,359	25
26	Insurance-Prop.Liab.Malpractice	0	0	961	0	0	0	0	0	0	0	0	961	26
27	Other (specify):*	0	0	10,172	0	0	0	0	0	0	0	0	10,172	27
28	TOTAL General Administration	(57)	19,865	51,047	0	70,855	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,946)	33,086	51,047	0	37,187	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Robings Manor Rehab & Health Care# 0026716

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(37,970)	0	2,491	0	0	0	0	0	0	0	0	(35,479)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	4,330	0	0	0	0	0	0	0	0	4,330	32
33	Real Estate Taxes	0	0	821	0	0	0	0	0	0	0	0	821	33
34	Rent-Facility & Grounds	0	0	50	0	0	0	0	0	0	0	0	50	34
35	Rent-Equipment & Vehicles	0	0	661	0	0	0	0	0	0	0	0	661	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(37,970)	0	8,353	0	(29,617)	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(63,472)	0	0	0	0	0	0	0	0	0	0	(63,472)	43
44	TOTAL Special Cost Centers	(63,472)	0	0	0	0	0	0	0	0	0	0	(63,472)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(148,388)	33,086	59,400	0	0	0	0	0	0	0	0	(55,902)	45

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%	\$ 2,099	\$ 2,099	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	73	73	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	24	24	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	358	358	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,924	2,924	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	958	958	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	5,550	5,550	8	
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,234	1,234	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	15,624	15,624	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	4,241	4,241	12	
13	V							13	
14	Total		\$			\$ 33,086	\$ *	33,086	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%	\$ 919	\$ 919	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	35,576	35,576	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	409	409	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	651	651	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	2,359	2,359	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	961	961	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,172	10,172	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,491	2,491	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,330	4,330	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	821	821	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	50	50	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	661	661	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		\$			\$ 59,400	\$ * 59,400	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	1.03	1.87	Salary	\$ 15,624	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	\$ 15,624		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 Robings Manor Rehab & Health Care

0026716

Report Period Beginning:

01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	0	66	\$ 110,171	\$ 109,587	0	\$ 2,099	1
2	2	Food	Resident Days	0	66	3,806	0	0	73	2
3	3	Housekeeping	Resident Days	0	66	1,250	0	0	24	3
4	4	Laundry	Resident Days	0	66	73	0	0	1	4
5	5	Utilities	Resident Days	0	66	18,812	0	0	358	5
6	6	Maintenance	Resident Days	0	66	153,468	113,063	0	2,924	6
7	7	Mgmt. Allocation of Benefits	Resident Days	0	66	50,271	0	0	958	7
8	10	Nursing and Medical Records	Resident Days	0	66	291,305	286,855	0	5,550	8
9	10A	Therapy	Resident Days	0	66	0	0	0	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	0	66	64,765	0	0	1,234	10
11	17	Administrative	Resident Days	0	66	820,116	820,116	0	15,624	11
12	19	Professional Services	Resident Days	0	66	222,628	0	0	4,241	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	0	66	48,243	0	0	919	13
14	21	Clerical and General Office	Resident Days	0	66	1,867,440	1,544,801	0	35,576	14
15	23	Inservice Training & Education	Resident Days	0	66	21,481	0	0	409	15
16	24	Travel and Seminar	Resident Days	0	66	34,177	0	0	651	16
17	25	Other Admin. Staff Transport.	Resident Days	0	66	123,847	0	0	2,359	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	0	66	50,427	0	0	961	18
19	27	Mgmt. Allocation of Benefits	Resident Days	0	66	533,953	0	0	10,172	19
20	30	Depreciation	Resident Days	0	66	130,767	0	0	2,491	20
21	32	Interest	Resident Days	0	66	227,295	0	0	4,330	21
22	33	Real Estate Taxes	Resident Days	0	66	43,090	0	0	821	22
23	34	Rent-Facility and Grounds	Resident Days	0	66	2,648	0	0	50	23
24	35	Rent-Equipment & Vehicles	Resident Days	0	66	34,690	0	0	661	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 92,486	25

Facility Name & ID Number

Robings Manor Rehab & Health Care

0026716

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	LaSalle Bank		X	Mortgage	Varies	1/17/07	\$ 3,225,000	\$ 3,188,343	12/31/13	Variable	\$ 277,827	1							
2												2							
3												3							
4							Home Office Allocation				4,330	4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 3,225,000	\$ 3,188,343			\$ 282,157	9							
B. Non-Facility Related*																			
10												10							
11							Amortization of Mortgage Costs				476	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 476	14							
15	TOTALS (line 9+line14)						\$ 3,225,000	\$ 3,188,343			\$ 282,633	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.)

Facility Name & ID Number Robings Manor Rehab & Health Care

0026716 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,072 B. General Construction Type: Exterior Brick Frame Wood 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).

Independent Living

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>42,108</u>	<u>1977</u>	<u>\$ 25,000</u>	<u>1</u>
2	<u>Facility</u>	<u>18,797</u>	<u>2003</u>	<u>159,891</u>	<u>2</u>
3	TOTALS	60,905		\$ 184,891	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	68	1977	1977	\$ 340,200	\$	25	\$	\$	\$ 340,200	4
5	7	2006	2006	1,319,360		25	35,183	35,183	70,366	5
6										6
7	Home Office Allocation			13,983			341	341		7
8										8
	Improvement Type**									
9	Various		1978	357		20			357	9
10	Various		1979	62,800		25			62,800	10
11	Various		1983	27,383		20			27,383	11
12	Various		1984	3,788		20			3,788	12
13	Various		1985	4,563		20			4,563	13
14	Various		1989	6,368		20			6,368	14
15	Various		1991	5,525		20	276	276	5,078	15
16	Various		1992	14,285		20	714	714	11,199	16
17	Various		1995	18,999		20	950	950	11,555	17
18										18
19	Tile flooring		1996	991		20	50	50	599	19
20	Curtains		1996	3,187		20	159	159	1,843	20
21	Mini blinds		1996	358		20	18	18	209	21
22	Concrete parking lot		1996	1,250		20	63	63	718	22
23	Paving and lining parking lot		1996	8,325		20	416	416	4,612	23
24										24
25	Electrical box		1997	3,777		20	189	189	2,079	25
26	Medicare survey		1997	1,543		20	77	77	809	26
27	Windows		1997	1,640		20	82	82	861	27
28	Screen patio		1997	8,369		20	418	418	4,320	28
29	Seal coat parking lot		1997	675		20	34	34	349	29
30										30
31	Landscaping		1998	4,553		15	304	304	2,782	31
32	Remodeling		1998	1,822		20	91	91	865	32
33	Siding & windows		1998	39,885		20	1,994	1,994	18,944	33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Outdoor sign	1999	\$ 1,036	\$	20	\$ 52	\$ 52	\$ 468	37
38	Sprinkler heads	1999	2,187		20	109	109	982	38
39	Handicapped bathrooms	1999	23,785		20	1,189	1,189	9,406	39
40	Nurse call system	1999	3,648		20	182	182	1,639	40
41									41
42	Roof	1999	21,735		20	1,087	1,087	9,783	42
43	Fencing	1999	2,777		20	139	139	1,251	43
44	Windows	1999	1,250		20	63	63	566	44
45									45
46	Garage & patio	1999	15,560		20	778	778	7,002	46
47									47
48	Windows	2000	1,233		20	62	62	464	48
49	Key system	2000	1,080		20	54	54	405	49
50	Resurface parking lot	2000	1,950		20	98	98	734	50
51									51
52	Kitchen remodeling	2001	2,152		20	108	108	701	52
53	Air compressor	2001	5,900		20	295	295	1,918	53
54	Carpet	2001	1,221		20	61	61	397	54
55	New roof - shed	2001	1,320		20	66	66	429	55
56	Remodel skilled units	2001	5,897		20	295	295	1,917	56
57									57
58	Building upgrades	2002	4,937		20	247	247	1,358	58
59	Nurses station cabinets	2002	2,369		20	118	118	650	59
60									60
61	Gutters and drains	2003	3,400		20	170	170	765	61
62	Hot water heater	2003	1,932		20	97	97	435	62
63									63
64	Boiler/Hot Water	2004	1,525		20	76	76	267	64
65	ADT Smoke detector	2004	6,176		20	309	309	1,081	65
66	Fire Suppression System	2004	1,920		20	96	96	336	66
67									67
68	Landscaping Improvements	2005	11,483		20	574	574	1,435	68
69	Architect Fees	2005	7,996		20	400	400	1,000	69
70	TOTAL (lines 4 thru 69)		\$ 2,028,455	\$		\$ 48,084	\$ 48,084	\$ 628,036	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,028,455	\$		\$ 48,084	\$ 48,084	\$ 628,036	1
2	Fire System	2006	10,250		25	410	410	513	2
3	Generator	2006	5,260		15	351	351	526	3
4	Carpeting	2007	590		10	30	30	30	4
5	HVAC in Laundry Building	2007	6,900		15	230	230	230	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23	Building Booked			52,774			(52,774)		23
24	Building Improvement Booked			38,750			(38,750)		24
25									25
26									26
27									27
28									28
29									29
30	2007-Home Office Allocation-Building Improvements		936			56	56		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,052,391	\$ 91,524		\$ 49,161	\$ (42,363)	\$ 629,335	34

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

Facility Name & ID Number **Robings Manor Rehab & Health Care**

0026716

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	\$ 198,719	\$ 15,365	\$ 19,872	\$ 4,507	10	\$ 179,067	71
72	Current Year Purchases	9,410	188	471	283	10	471	72
73	Fully Depreciated Assets	113,003					113,003	73
74	Home Office Allocation			2,094	2,094			74
75	TOTALS	\$ 321,132	\$ 15,553	\$ 22,437	\$ 6,884		\$ 292,541	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	89 Ford Van	1993	\$ 10,795	\$	\$	\$	5	\$ 10,795	76
77	Facility	Hossler Van	1999	40,785				5	40,785	77
78										78
79										79
80	TOTALS			\$ 51,580	\$	\$	\$		\$ 51,580	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,609,994	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 107,077	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,598	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (35,479)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 973,456	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	Independent Living-2006	\$ 670,000	\$ 16,750	\$ 43,550	86
87	Independent Living-2007	15,749	863	863	87
88					88
89					89
90					90
91	TOTALS	\$ 685,749	\$ 17,613	\$ 44,413	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		<u>Home Office Allocation</u>			<u>50</u>			6
7	TOTAL				\$ <u>50</u>			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,192 Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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

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

Robings Manor Rehab & Health Care

0026716

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 4,243
Dishwasher	806
Nursing Equipment	3,482
Home Office Allocation	661
	<u>9,192</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	\$	6,762	\$ 101,436	\$	6,762	\$ 101,436	1
2	Licensed Speech and Language Development Therapist	10a(3)	hrs		3,290	49,355		3,290	49,355	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a(3)	hrs		5,205	78,172	604	5,205	78,776	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				71,229		71,229	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	15,257	\$ 228,963	\$ 71,833	15,257	\$ 300,796	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 Robings Manor Rehab & Health Care# 0026716Report Period Beginning: 01/01/2007Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,638,489	\$ 1,638,489	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>n/a</u>)	410,639	410,639	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,399	12,399	6
7	Other Prepaid Expenses	3,181	3,181	7
8	Accounts Receivable (owners or related parties)	1,058,875	1,058,875	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,123,583	\$ 3,123,583	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	219,058	184,891	13
14	Buildings, at Historical Cost	372,302	1,673,543	14
15	Leasehold Improvements, at Historical Cost	2,318,465	378,848	15
16	Equipment, at Historical Cost	394,010	372,712	16
17	Accumulated Depreciation (book methods)	(1,025,039)	(973,456)	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>Loan Cost</u>)	9,524	9,524	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,288,320	\$ 1,646,062	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,411,903	\$ 4,769,645	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 372,834	\$ 372,834	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,042	70,042	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,827	2,827	31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,000	13,000	32
33	Accrued Interest Payable	22,669	22,669	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	23,176	23,176	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 504,548	\$ 504,548	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,188,343	3,188,343	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>A/P-Prior Owner</u>	1,000	1,000	43
44	<u>A/P-Other</u>	4,502	4,502	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,193,845	\$ 3,193,845	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,698,393	\$ 3,698,393	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,713,510	\$ 1,071,252	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,411,903	\$ 4,769,645	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,182,226	1
2	Restatements (describe):		2
3	Post Cost Report Audit Adjustments	(19,171)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,163,055	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	550,455	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 550,455	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)	\$ 1,713,510	24 *

* This must agree with page 17, line 47.

Robings Manor Rehab & Health Care
0026716
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 18A

XVI. Statement of Changes in Equity

Beginning Equity Restatements:

Post Cost Report Audit Adjustments

After filing the previous year's State of Illinois Financial and Statistical Report for Long-Term Care Facilities, an adjustment was made to the facility's financial records to properly state bad debt expense. Therefore, an adjustment to the current year's beginning equity is necessary to reconcile the previous year's cost report equity to the current year's equity per books. After this adjustment, cost report equity agrees to book equity on Schedule XVI.

Facility Name & ID Number **Robings Manor Rehab & Health Care**# **0026716**Report Period Beginning: **01/01/2007**Ending: **12/31/2007**

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	\$ 2,536,225	1
2	Discounts and Allowances for all Levels	61,218	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,597,443	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	326,829	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 326,829	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,772	14
15	Telephone, Television and Radio	2,313	15
16	Rental of Facility Space		16
17	Sale of Drugs	117,364	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,004	20
21	Other Medical Services	3,545	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 135,998	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	2,007	28
28a	Transportation Revenue	34	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,041	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,062,311	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	540,966	31
32	Health Care	1,053,571	32
33	General Administration	333,780	33
B. Capital Expense			
34	Ownership	407,775	34
C. Ancillary Expense			
35	Special Cost Centers	134,701	35
36	Provider Participation Fee	41,063	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,511,856	40
41	Income before Income Taxes (line 30 minus line 40)**	550,455	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 550,455	43

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

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

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

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

Facility Name & ID Number **Robings Manor Rehab & Health Care**

0026716

Report Period Beginning: **01/01/2007**

Ending:

12/31/2007

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,749	1,749	\$ 40,415	\$ 23.11	1
2	Assistant Director of Nursing	2,080	2,080	39,113	18.80	2
3	Registered Nurses	5,581	5,717	114,709	20.06	3
4	Licensed Practical Nurses	9,444	9,684	167,766	17.32	4
5	CNAs & Orderlies	37,111	37,988	344,568	9.07	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,085	2,085	20,431	9.80	9
10	Activity Assistants					10
11	Social Service Workers	1,959	1,959	21,754	11.10	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	18,730	9.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,425	11,598	83,000	7.16	15
16	Dishwashers					16
17	Maintenance Workers	1,979	1,979	26,265	13.27	17
18	Housekeepers	9,308	9,630	71,871	7.46	18
19	Laundry	6,273	6,303	44,121	7.00	19
20	Administrator	2,356	2,356	84,771	35.98	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,344	2,344	31,718	13.53	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coord.	1,668	1,856	21,489	11.58	32
33	Other(specify) <u>See Attach. 20A</u>	2,060	2,060	33,455	16.24	33
34	TOTAL (lines 1 - 33)	99,502	101,468	\$ 1,164,176 *	\$ 11.47	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	17	\$ 885	1(3)	35
36	Medical Director	Monthly	13,750	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	525	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)	17	\$ 15,160		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	91	2,811	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	91	\$ 2,811		53

Schedule 20A

XVIII. Staffing and Salary Costs
Line 32-Other

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing	1,867	1,867	31,911	17.09
Transportation	193	193	1,544	8.00
Total Line 32-Other	2,060	2,060	33,455	16.24

Robings Manor Rehab & Health Care
0026716

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
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Total (agree to Schedule V, line 19, column 3)		13,251
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Non-allowable legal expense		-
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(Real Estate Entity)

Legal
Accountants
Accountants

Non-allowable Legal

Home Office Allocation

Pearl & Associates	Legal	28
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Addy Bush & Assoc	Legal	14
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Registered Agent Solutions	Legal	2
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Heyl, Royster, Voelker & Allen	Legal	61
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Duane Morris	Legal	95
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Ginoli & Co.	Accountants	970
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RSM McGladrey	Accountants	168
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McGladrey & Pullen	Accountants	256
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Emdeon Business Services	Computer Services	67
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Advanced Answers on Demand	Computer Services	1,798
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Access 2 Go	Computer Services	136
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Ivans	Computer Services	119
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Kemper Technology	Computer Services	282
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Adminastar Federal	Computer Services	35
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Logmein	Computer Services	22
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E-Health Data Solutions	Computer Services	176
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Miscellaneous Vendors	Miscellaneous	12
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Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)		<u>17,492</u>
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Facility Name & ID Number Robings Manor Rehab & Health Care# 0026716Report Period Beginning: 01/01/2007 Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-\$4,778
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,798 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 41,063
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? Yes-See Sch 23A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,772
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A 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.

Robings Manor Rehab & Health Care

0026716

Period Beginning 01/01/2007

Period End 12/31/2007

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	2,283	8.34%
Nursing Home	25,081	91.66%
	<u>27,364</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	118,224	8.34%	9,860	Census	1
Food	125,120	8.34%	10,435	Census	2
Housekeeping	87,002	8.34%	7,256	Census	3
Laundry	59,563	8.34%	4,968	Census	4
Utilities	80,422	8.34%	6,707	Census	5
Maintenance	70,635	8.34%	5,891	Census	6
Depreciation (Building)	<u>17,613</u>	100.00%	<u>17,613</u>	S/L Depr	30
Total	<u>558,579</u>		<u>62,730</u>		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on straight-line depreciation over an estimated useful life of 25 years. Independent Living overhead and depreciation cost have been offset on P5A.