

Facility Name & ID Number Robings Manor Rehab & Health Care

0026716 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	32	Skilled (SNF)	32	11,712	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,738	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,450	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,534	1,534	8
9	SNF/PED					9
10	ICF	16,830	5,605		22,435	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,830	5,605	1,534	23,969	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.32%

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 _____ 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 1,534

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number

Robings Manor Rehab & Health Care

0026716

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	111,691	16,781	3,880	132,352		132,352	(5,058)	127,294		1
2	Food Purchase		122,449		122,449		122,449	(11,082)	111,367		2
3	Housekeeping	76,251	13,641		89,892		89,892	(6,810)	83,082		3
4	Laundry	42,603	15,575		58,178		58,178	(4,425)	53,753		4
5	Heat and Other Utilities			87,476	87,476		87,476	(6,216)	81,260		5
6	Maintenance	26,792	8,097	25,051	59,940		59,940	(1,957)	57,983		6
7	Other (specify):* Home Off. Ben. All.							1,047	1,047		7
8	TOTAL General Services	257,337	176,543	116,407	550,287		550,287	(34,501)	515,786		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	715,075	23,145	609	738,829		738,829	7,394	746,223		10
10a	Therapy			187,866	187,866		187,866		187,866		10a
11	Activities	22,970	660	2,229	25,859		25,859	(72)	25,787		11
12	Social Services	19,710	10		19,720		19,720		19,720		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,291	1,291		15
16	TOTAL Health Care and Programs	757,755	23,815	205,104	986,674		986,674	8,613	995,287		16
	C. General Administration										
17	Administrative	60,326			60,326		60,326	33,166	93,492		17
18	Directors Fees										18
19	Professional Services			4,780	4,780		4,780	3,743	8,523		19
20	Dues, Fees, Subscriptions & Promotions			6,881	6,881		6,881	1,015	7,896		20
21	Clerical & General Office Expenses	30,759	5,574	7,505	43,838		43,838	41,294	85,132		21
22	Employee Benefits & Payroll Taxes			205,787	205,787		205,787		205,787		22
23	Inservice Training & Education							253	253		23
24	Travel and Seminar							253	253		24
25	Other Admin. Staff Transportation			5,787	5,787		5,787	3,277	9,064		25
26	Insurance-Prop.Liab.Malpractice			547,348	547,348		547,348	200	547,548		26
27	Other (specify):* Home Off. Ben. All.							11,849	11,849		27
28	TOTAL General Administration	91,085	5,574	778,088	874,747		874,747	95,050	969,797		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,106,177	205,932	1,099,599	2,411,708		2,411,708	69,162	2,480,870		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:

1/1/2008

Ending:

12/31/2008

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			105,815	105,815		105,815	(30,724)	75,091		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			212,160	212,160		212,160	3,204	215,364		32
33	Real Estate Taxes			15,350	15,350		15,350	608	15,958		33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			5,112	5,112		5,112	519	5,631		35
36	Other (specify):*										36
37	TOTAL Ownership			338,437	338,437		338,437	(26,393)	312,044		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		46,968		46,968		46,968		46,968		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			41,176	41,176		41,176		41,176		42
43	Other (specify):* Non-Allowable Costs	7,000	226	57,314	64,540		64,540	(64,540)			43
44	TOTAL Special Cost Centers	7,000	47,194	98,490	152,684		152,684	(64,540)	88,144		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,113,177	253,126	1,536,526	2,902,829		2,902,829	(21,771)	2,881,058		45

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

Robings Manor Rehab & Health Care

ID# 0026716

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Labs-Part A	\$ (2,098)	43	1
2	X-Rays-Part A	2,061	43	2
3	Disallowed Special Events	(113)	43	3
4	Resident Flowers	(1,304)	43	4
5	Disallowed Dues	(140)	20	5
6	Independent Living Dietary Cost Offset	(10,072)	1	6
7	Independent Living Food Cost Offset	(9,318)	2	7
8	Independent Living Housekeeping Cost Offset	(6,841)	3	8
9	Independent Living Laundry Cost Offset	(4,427)	4	9
10	Independent Living Utilities Cost Offset	(6,657)	5	10
11	Independent Living Maintenance Cost Offset	(4,561)	6	11
12	Offset of Miscellaneous Income	(326)	21	12
13	Offset of Transportation Income	(72)	11	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	(43,868)		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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 4,260	\$ 4,260	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	70	70	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	31	31	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	2	2	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	441	441	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	2,604	2,604	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,047	1,047	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	7,394	7,394	8	
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,291	1,291	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	33,166	33,166	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	3,743	3,743	12	
13	V							13	
14	Total		\$			\$ 54,049	\$ *	54,049	14

* 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: 1/1/2008

Ending: 12/31/2008

VII. RELATED PARTIES (continued)

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

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

1	2	3	4	5	6	7	8		
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)		
15	V	20	Dues, Fees, Subs and Prmotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,155	\$ 1,155	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	41,620	41,620	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	253	253	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	253	253	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,277	3,277	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	200	200	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,849	11,849	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,534	4,534	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	3,190	3,190	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	608	608	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%	519	519	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		\$				\$ 67,458	\$ * 67,458	39

* 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:

1/1/2008

Ending:

12/31/2008

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	1,795,508	1.00	1.66	Salary	33,166	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	\$ 33,166		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: 1/1/2008

Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 23,969	\$ 4,260	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	70	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	31	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	2	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	441	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	2,604	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	1,047	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	7,394	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	1,291	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	33,166	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	3,743	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	1,155	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	41,620	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	253	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	253	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	3,277	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	200	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	11,849	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	4,534	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	3,190	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	608	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	519	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358	\$ 121,507	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	Bank of America		X	Mortgage	Varies	1/17/07	\$ 3,225,000	\$ 3,145,044	12/31/13	Variable	\$ 202,636	1								
2												2								
3							Interest Income Offset				14	3								
4							Home Office Allocation-PHC				3,190	4								
5												5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 3,225,000	\$ 3,145,044			\$ 205,840	9								
B. Non-Facility Related*																				
10												10								
11							Amortization of Mortgage Costs				9,524	11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 9,524	14								
15	TOTALS (line 9+line14)						\$ 3,225,000	\$ 3,145,044			\$ 215,364	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.)

IMPORTANT NOTICE

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

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

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

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

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Robings Manor Rehab & Health Care COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0026716

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-001-047-00</u>	<u>Lot 12, Albro Palmers etal sub div</u>	<u>\$ 5,833.68</u>	<u>\$ 5,833.68</u>
2. <u>21-001-048-00</u>	<u>N Pt Lot 13 A Palmers etal sub div</u>	<u>\$ 7,319.62</u>	<u>\$ 7,319.62</u>
3. <u>21-001-049-00</u>	<u>40 Ctr Lot 13 A Palmers etal sub div</u>	<u>\$ 696.28</u>	<u>\$ 696.28</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>13,849.58</u>	\$ <u>13,849.58</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	42,108	1977	\$ 25,000	1
2	Facility	18,797	2003	159,891	2
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	105,549	5
6											6
7	Home Office Allocation										
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	5,354	15
16	Various		1992		14,285		20	714	714	11,913	16
17	Various		1995		18,999		20	950	950	12,505	17
18	Tile flooring		1996		991		20	50	50	649	18
19	Curtains		1996		3,187		20	159	159	2,002	19
20	Mini blinds		1996		358		20	18	18	227	20
21	Concrete parking lot		1996		1,250		20	63	63	781	21
22	Paving and lining parking lot		1996		8,325		20	416	416	5,028	22
23	Electrical box		1997		3,777		20	189	189	2,268	23
24	Medicare survey		1997		1,543		20	77	77	886	24
25	Windows		1997		1,640		20	82	82	943	25
26	Screen patio		1997		8,369		20	418	418	4,738	26
27	Seal coat parking lot		1997		675		20	34	34	383	27
28	Landscaping		1998		4,553		15	304	304	3,086	28
29	Remodeling		1998		1,822		20	91	91	956	29
30	Siding & windows		1998		39,885		20	1,994	1,994	20,938	30
31	Outdoor sign		1999		\$ 1,036	\$	20	\$ 52	\$ 52	\$ 520	31
32	Sprinkler heads		1999		2,187		20	109	109	1,091	32
33	Handicapped bathrooms		1999		23,785		20	1,189	1,189	10,595	33
34	Nurse call system		1999		3,648		20	182	182	1,821	34
35											35
36											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

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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	Roof	1999	21,735		20	1,087	1,087	10,870	37
38	Fencing	1999	2,777		20	139	139	1,390	38
39	Windows	1999	1,250		20	63	63	629	39
40	Garage & patio	1999	15,560		20	778	778	7,780	40
41	Windows	2000	1,233		20	62	62	526	41
42	Key system	2000	1,080		20	54	54	459	42
43	Resurface parking lot	2000	1,950		20	98	98	832	43
44	Kitchen remodeling	2001	2,152		20	108	108	809	44
45	Air compressor	2001	5,900		20	295	295	2,213	45
46	Carpet	2001	1,221		20	61	61	458	46
47	New roof - shed	2001	1,320		20	66	66	495	47
48	Remodel skilled units	2001	5,897		20	295	295	2,212	48
49	Building upgrades	2002	4,937		20	247	247	1,605	49
50	Nurses station cabinets	2002	2,369		20	118	118	768	50
51	Gutters and drains	2003	3,400		20	170	170	935	51
52	Hot water heater	2003	1,932		20	97	97	532	52
53	Boiler/Hot Water	2004	1,525		20	76	76	343	53
54	ADT Smoke detector	2004	6,176		20	309	309	1,390	54
55	Fire Suppression System	2004	1,920		20	96	96	432	55
56	Landscaping Improvements	2005	11,483		20	574	574	2,009	56
57	Architect Fees	2005	7,996		20	400	400	1,400	57
58	Fire System	2006	10,250		25	410	410	923	58
59	Generator	2006	5,260		15	351	351	877	59
60	Carpeting	2007	590		10	59	59	89	60
61	HVAC in Laundry Building	2007	6,900		15	460	460	690	61
62	Tile Replacement	2008	11,066		15	369	369	369	62
63									63
64	Building Booked						(52,774)		64
65	Building Improvement Booked						(39,723)		65
66									66
67	2008-Home Office Allocation-Building		12,445			298	298		67
68	2008-Home Office Allocation-Building Improvements		833			54	54		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,061,816	\$ 92,497		\$ 49,744	\$ (42,753)	\$ 678,727	70

**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:

1/1/2008

Ending:

12/31/2008

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	\$ 208,129	\$ 13,318	\$ 20,813	\$ 7,495		\$ 200,351	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	113,003					113,003	73
74	Home Office Allocation			4,534	4,534			74
75	TOTALS	\$ 321,132	\$ 13,318	\$ 25,347	\$ 12,029		\$ 313,354	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	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,619,419	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,815	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 75,091	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (30,724)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,043,661	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	\$ 26,800	\$ 70,350	86
87	Independent Living-2007	15,749	1,726	2,589	87
88					88
89					89
90					90
91	TOTALS	\$ 685,749	\$ 28,526	\$ 72,939	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.

Robings Manor Rehab & Health Care

0026716

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	707
Dishwasher		708
Copier		3,697
Home Office Allocation		519
		<u>5,631</u>

See CR for Home Office Allocation

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)	hrs	\$	4,152	\$ 62,276	\$	4,152	\$ 62,276	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,856	42,847		2,856	42,847	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,729	82,668		5,729	82,668	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				46,968		46,968	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>				5	75		5	75	13
14	TOTAL			\$	12,742	\$ 187,866	\$ 46,968	12,742	\$ 234,834	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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Robings Manor Rehab & Health Care# 0026716Report Period Beginning: 1/1/2008Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,206,077	\$ 2,206,077	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	521,953	521,953	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,661	18,661	6
7	Other Prepaid Expenses	8,988	8,988	7
8	Accounts Receivable (owners or related parties)	1,063,568	1,063,568	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,819,247	\$ 3,819,247	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	1,672,005	14
15	Leasehold Improvements, at Historical Cost	2,329,530	389,811	15
16	Equipment, at Historical Cost	394,010	372,712	16
17	Accumulated Depreciation (book methods)	(1,130,854)	(1,043,661)	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 (spec: <u>Loan Cost</u>)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,184,046	\$ 1,575,758	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,003,293	\$ 5,395,005	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 943,619	\$ 943,619	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,144	70,144	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,228	2,228	31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,500	14,500	32
33	Accrued Interest Payable	18,526	18,526	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	21,992	21,992	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,071,009	\$ 1,071,009	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,145,044	3,145,044	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposit</u>	3,500	3,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,148,544	\$ 3,148,544	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,219,553	\$ 4,219,553	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,783,740	\$ 1,175,452	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,003,293	\$ 5,395,005	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,713,510	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)	\$ 1,713,509	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	70,231	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)	\$ 70,231	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)	\$ 1,783,740	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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

0026716

Report Period Beginning: **1/1/2008**

Ending: **12/31/2008**

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	\$ 2,564,510	1
2	Discounts and Allowances for all Levels	30,389	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,594,899	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	282,930	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 282,930	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	1,080	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	78,253	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,324	20
21	Other Medical Services	2,190	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 94,847	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(14)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (14)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	326	28
28a	<u>Transportation Revenue</u>	72	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 398	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,973,060	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	550,287	31
32	Health Care	986,674	32
33	General Administration	874,747	33
B. Capital Expense			
34	Ownership	338,437	34
C. Ancillary Expense			
35	Special Cost Centers	111,508	35
36	Provider Participation Fee	41,176	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,902,829	40
41	Income before Income Taxes (line 30 minus line 40)**	70,231	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 70,231	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 **Robings Manor Rehab & Health Care**

0026716

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	837	837	\$ 18,165	\$ 21.70	1
2	Assistant Director of Nursing	2,080	2,080	40,690	19.56	2
3	Registered Nurses	3,728	3,996	78,066	19.54	3
4	Licensed Practical Nurses	11,991	12,175	225,192	18.50	4
5	CNAs & Orderlies	34,296	35,367	330,026	9.33	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	22,458	10.80	9
10	Activity Assistants					10
11	Social Service Workers	2,079	2,079	19,710	9.48	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	24,996	12.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,858	11,113	86,695	7.80	15
16	Dishwashers					16
17	Maintenance Workers	2,056	2,056	26,792	13.03	17
18	Housekeepers	9,513	9,717	76,251	7.85	18
19	Laundry	5,383	5,449	42,603	7.82	19
20	Administrator	2,080	2,080	60,326	29.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,387	2,387	30,759	12.89	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 Care(specify)					32
33	Other(specify) <u>See Sch. PG20A</u>	2,197	2,355	30,448	12.93	33
34	TOTAL (lines 1 - 33)	93,645	95,851	\$ 1,113,177 *	\$ 11.61	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	68	\$ 3,880	1(3)	35
36	Medical Director	Monthly	14,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	550	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)	68	\$ 18,830		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

Robings Manor Rehab & Health Care

0026716

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Restorative Aide	1,682	1,840	22,936	12.47
Marketing	450	450	7,000	15.56
Transportation	65	65	512	7.88
TOTAL (lines 1 - 35)	<u>2,197</u>	<u>2,355</u>	<u>30,448</u>	

Robings Manor Rehab & Health Care

0026716

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,780

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	136
GoffWilson, P.A.	Legal	454
Ginoli & Company	Accountants	1,104
RSM McGladrey	Accountants	10
Emdeon Business Services	Computer Services	53
Advanced Answers on Demand	Computer Services	73
Access 2 Go	Computer Services	860
Ivans	Computer Services	254
Kemper Technology	Computer Services	132
VisionShare	Computer Services	466
Logmein	Computer Services	50
Comm Net Communiations	Computer Services	36
Charter Communications	Computer Services	13
Advanced System Designs	Computer Services	11
Consolidated Communications	Computer Services	17
Miscellaneous Vendors	Computer Services	10
Miscellaneous Vendors	Miscellaneous	64

Total (agree to Schedule V, line 19, column 8)	<u><u>8,523</u></u>
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Robings Manor Rehab & Health Care

0026716

Period Beginning

1/1/2008

Period End

12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Shaw	Administrator	0	60,326
		Total	<u>60,326</u>

Facility Name & ID Number Robings Manor Rehab & Health Care# 0026716Report Period Beginning: 1/1/2008Ending: 12/31/2008**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 2,890 -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. \$ 2,362 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 YES NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO 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. \$ 41,176
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. \$ 5,058
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Robings Manor Rehab & Health Care

0026716

Period Beginning 1/1/2008

Period End 12/31/2008

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	1,975	7.61%
Nursing Home	23,969	92.39%
	<u>25,944</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	132,352	7.61%	10,072	Census	1
Food	122,449	7.61%	9,318	Census	2
Housekeeping	89,892	7.61%	6,841	Census	3
Laundry	58,178	7.61%	4,427	Census	4
Utilities	87,476	7.61%	6,657	Census	5
Maintenance	59,940	7.61%	4,561	Census	6
Depreciation (Building)	<u>28,526</u>	100.00%	<u>28,526</u>	S/L Depr	30
Total	<u><u>578,813</u></u>		<u><u>70,402</u></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.