

Facility Name & ID Number Robings Manor Rehab & Health Care

0026716 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<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				5 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF			<u>1,309</u>	<u>1,309</u>		8
9	SNF/PED						9
10	ICF	<u>16,530</u>	<u>3,963</u>		<u>20,493</u>		10
11	ICF/DD						11
12	SC						12
13	DD 16 OR LESS						13
14	TOTALS	<u>16,530</u>	<u>3,963</u>	<u>1,309</u>	<u>21,802</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.64%

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 1/1/1977

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 32 and days of care provided 1,309

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	112,658	15,613	1,038	129,309		129,309	(7,010)	122,299		1
2	Food Purchase		127,117		127,117		127,117	(12,222)	114,895		2
3	Housekeeping	65,894	17,645		83,539		83,539	(6,956)	76,583		3
4	Laundry	51,073	19,392		70,465		70,465	(5,898)	64,567		4
5	Heat and Other Utilities			78,711	78,711		78,711	(6,212)	72,499		5
6	Maintenance	28,001	11,476	18,874	58,351		58,351	(3,037)	55,314		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							688	688		7
8	TOTAL General Services	257,626	191,243	98,623	547,492		547,492	(40,647)	506,845		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	775,622	45,330	10,649	831,601		831,601	2,010	833,611		10
10a	Therapy		100	172,323	172,423		172,423		172,423		10a
11	Activities	23,967	1,227	347	25,541		25,541	(262)	25,279		11
12	Social Services	16,725	23		16,748		16,748		16,748		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							284	284		15
16	TOTAL Health Care and Programs	816,314	46,680	197,719	1,060,713		1,060,713	2,032	1,062,745		16
	C. General Administration										
17	Administrative	20,073			20,073		20,073	62,854	82,927		17
18	Directors Fees										18
19	Professional Services			4,971	4,971		4,971	5,346	10,317		19
20	Dues, Fees, Subscriptions & Promotions			5,143	5,143		5,143	1,462	6,605		20
21	Clerical & General Office Expenses	32,043	3,622	6,965	42,630		42,630	38,604	81,234		21
22	Employee Benefits & Payroll Taxes			267,150	267,150		267,150		267,150		22
23	Inservice Training & Education							397	397		23
24	Travel and Seminar							122	122		24
25	Other Admin. Staff Transportation			4,434	4,434		4,434	1,916	6,350		25
26	Insurance-Prop.Liab.Malpractice			57,778	57,778		57,778	795	58,573		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							10,436	10,436		27
28	TOTAL General Administration	52,116	3,622	346,441	402,179		402,179	121,932	524,111		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,126,056	241,545	642,783	2,010,384		2,010,384	83,317	2,093,701		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: 1/1/2009 Ending: 12/31/2009

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			102,415	102,415		102,415	(28,193)	74,222			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			174,485	174,485		174,485	3,404	177,889			32
33	Real Estate Taxes			13,928	13,928		13,928	483	14,411			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			9,052	9,052		9,052	462	9,514			35
36	Other (specify):*											36
37	TOTAL Ownership			299,880	299,880		299,880	(23,844)	276,036			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		57,730		57,730		57,730		57,730			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		13	84,161	84,174		84,174	(84,174)				43
44	TOTAL Special Cost Centers		57,743	125,224	182,967		182,967	(84,174)	98,793			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,126,056	299,288	1,067,887	2,493,231		2,493,231	(24,701)	2,468,530			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 CareID# 0026716Report Period Beginning: 1/1/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,084)	43	1
2	X-Rays-Part A	(4,148)	43	2
3	Disallowed Special Events	(1,630)	43	3
4	Resident Flowers	(1,110)	43	4
5	Disallowed Dues	(28)	20	5
6	Independent Living Dietary Cost Offset	(10,823)	1	6
7	Independent Living Food Cost Offset	(10,640)	2	7
8	Independent Living Housekeeping Cost Offset	(6,992)	3	8
9	Independent Living Laundry Cost Offset	(5,898)	4	9
10	Independent Living Utilities Cost Offset	(6,588)	5	10
11	Independent Living Maintenance Cost Offset	(4,884)	6	11
12	Offset of Office Supplies Income	(273)	21	12
13	Offset of Transportation Income	(262)	11	13
14	Independent Living Depreciation Offset	(28,526)	30	14
15	Offset of Nursing Supplies Income	(297)	10	15
16	Interest Paid on Medicare Withholding	(103)	32	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	(84,286)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 3,813	\$ 3,813	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	86	86	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	36	36	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	376	376	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,847	1,847	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	688	688	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,307	2,307	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%	284	284	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	62,854	62,854	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,346	5,346	12	
13	V							13	
14	Total		\$			\$ 77,637	\$ *	77,637	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,490	\$	1,490	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	38,877		38,877	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	397		397	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	122		122	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,916		1,916	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	795		795	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	10,436		10,436	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	3,142		3,142	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,833		4,833	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	483		483	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%	462		462	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		\$			\$ 62,953	\$ *	62,953	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: 1/1/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	156,634	0.85	1.42	Salary	\$ 2,479	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	\$ 2,479		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:

1/1/2009Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, 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	1,493,044	75	\$ 261,102	\$ 259,584	21,802	\$ 3,813	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	21,802	86	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	21,802	36	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	21,802	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	21,802	376	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	21,802	1,847	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	21,802	688	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	21,802	2,307	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	21,802	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	21,802	284	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	21,802	62,854	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	21,802	5,346	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	21,802	1,490	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	21,802	38,877	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	21,802	397	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	21,802	122	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	21,802	1,916	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	21,802	795	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	21,802	10,436	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	21,802	3,142	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	21,802	4,833	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	21,802	483	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	21,802	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	21,802	462	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 140,590	25

Facility Name & ID Number

Robings Manor Rehab & Health Care

0026716

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	Bank of America		X	Mortgage	Varies	1/17/07	\$ 3,225,000	\$ 3,098,002	12/31/13	Variable	\$ 174,382	1							
2												2							
3							Interest Income Offset				(1,326)	3							
4							Home Office Allocation-PHC				4,833	4							
5												5							
Working Capital																			
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$ 3,225,000	\$ 3,098,002			\$ 177,889	9							
B. Non-Facility Related*																			
10							Interest Paid on Medicare Withholding				103	10							
11							Interest Offset on Medicare Withholding Interest Paid				(103)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 3,225,000	\$ 3,098,002			\$ 177,889	15							

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

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ 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	Facility	42,108	1977	\$ 25,000	1
2	Facility	18,797	2003	159,891	2
3	TOTALS	60,905		\$ 184,891	3

Facility Name & ID Number Robings Manor Rehab & Health Care

0026716

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	140,732	5
6											6
7											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	171	171	5,525	15
16	Various		1992		14,285		20	714	714	12,627	16
17	Various		1995		18,999		20	950	950	13,455	17
18	Tile flooring		1996		991		20	50	50	699	18
19	Curtains		1996		3,187		20	159	159	2,161	19
20	Mini blinds		1996		358		20	18	18	245	20
21	Concrete parking lot		1996		1,250		20	63	63	844	21
22	Paving and lining parking lot		1996		8,325		20	416	416	5,444	22
23	Electrical box		1997		3,777		20	189	189	2,457	23
24	Medicare survey		1997		1,543		20	77	77	963	24
25	Windows		1997		1,640		20	82	82	1,025	25
26	Screen patio		1997		8,369		20	418	418	5,156	26
27	Seal coat parking lot		1997		675		20	34	34	417	27
28	Landscaping		1998		4,553		15	304	304	3,390	28
29	Remodeling		1998		1,822		20	91	91	1,047	29
30	Siding & windows		1998		39,885		20	1,994	1,994	22,932	30
31	Outdoor sign		1999		\$ 1,036	\$	20	\$ 52	\$ 52	\$ 572	31
32	Sprinkler heads		1999		2,187		20	109	109	1,200	32
33	Handicapped bathrooms		1999		23,785		20	1,189	1,189	11,784	33
34	Nurse call system		1999		3,648		20	182	182	2,003	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:

1/1/2009

Ending:

12/31/2009

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	Roof	1999	21,735		20	1,087	1,087	11,957	37
38	Fencing	1999	2,777		20	139	139	1,529	38
39	Windows	1999	1,250		20	63	63	692	39
40	Garage & patio	1999	15,560		20	778	778	8,558	40
41	Windows	2000	1,233		20	62	62	588	41
42	Key system	2000	1,080		20	54	54	513	42
43	Resurface parking lot	2000	1,950		20	98	98	930	43
44	Kitchen remodeling	2001	2,152		20	108	108	917	44
45	Air compressor	2001	5,900		20	295	295	2,508	45
46	Carpet	2001	1,221		20	61	61	519	46
47	New roof - shed	2001	1,320		20	66	66	561	47
48	Remodel skilled units	2001	5,897		20	295	295	2,507	48
49	Building upgrades	2002	4,937		20	247	247	1,852	49
50	Nurses station cabinets	2002	2,369		20	118	118	886	50
51	Gutters and drains	2003	3,400		20	170	170	1,105	51
52	Hot water heater	2003	1,932		20	97	97	629	52
53	Boiler/Hot Water	2004	1,525		20	76	76	419	53
54	ADT Smoke detector	2004	6,176		20	309	309	1,699	54
55	Fire Suppression System	2004	1,920		20	96	96	528	55
56	Landscaping Improvements	2005	11,483		20	574	574	2,583	56
57	Architect Fees	2005	7,996		20	400	400	1,800	57
58	Fire System	2006	10,250		25	410	410	1,333	58
59	Generator	2006	5,260		15	351	351	1,228	59
60	Carpeting	2007	590		10	59	59	148	60
61	HVAC in Laundry Building	2007	6,900		15	460	460	1,150	61
62	Tile Replacement	2008	11,066		15	738	738	1,107	62
63	Sprinkler Installation on Outside Porch	2009	2,600		15	87	87	87	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,051,138	\$		\$ 49,743	\$ 49,743	\$ 728,470	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		\$ 2,051,138	\$		\$ 49,743	\$ 49,743	\$ 728,470	1
2									2
3									3
4									4
5									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	Land Improvement Booked			2,067			(2,067)		23
24	Building Improvement Booked			90,469			(90,469)		24
25									25
26									26
27	2009-Home Office Allocation-Land Improvements		717			45	45		27
28	2009-Home Office Allocation-Building Improvements		10,718			257	257		28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,062,573	\$ 92,536		\$ 50,045	\$ (42,491)	\$ 728,470	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:

1/1/2009

Ending:

12/31/2009

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	\$ 9,827	\$ 20,813	\$ 10,986	3-10 yrs.	\$ 163,757	71
72	Current Year Purchases	4,431	52	222	170	10 yrs.	222	72
73	Fully Depreciated Assets	113,003					113,003	73
74	Home Office Allocation			3,142	3,142			74
75	TOTALS	\$ 325,563	\$ 9,879	\$ 24,177	\$ 14,298		\$ 276,982	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	\$	\$	\$		\$ 10,795	76
77	Facility	Hossler Van	1999	40,785					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)	\$ 2,624,607	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,415	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 74,222	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (28,193)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,057,032	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	\$ 97,150	86
87	Independent Living-2007	15,749	1,726	4,315	87
88					88
89					89
90					90
91	TOTALS	\$ 685,749	\$ 28,526	\$ 101,465	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 9,514 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

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

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

Robings Manor Rehab & Health Care
0026716
Period Beginning 1/1/2009
Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	4,638
Dishwasher		708
Copier		3,706
Home Office Allocation		462
		<u>9,514</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? <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	\$	3,827	\$ 57,401	\$	3,827	\$ 57,401	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,666	39,987		2,666	39,987	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		4,996	74,935	100	4,996	75,035	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				57,730		57,730	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	11,489	\$ 172,323	\$ 57,830	11,489	\$ 230,153	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

0026716

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 2,846,417	\$ 2,846,417	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	232,884	232,884	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,387	37,387	6
7	Other Prepaid Expenses	10,964	10,964	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)	\$ 4,191,220	\$ 4,191,220	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	1,670,278	14
15	Leasehold Improvements, at Historical Cost	2,332,130	392,295	15
16	Equipment, at Historical Cost	398,442	377,143	16
17	Accumulated Depreciation (book methods)	(1,233,270)	(1,057,032)	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 Costs</u>)			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,088,662	\$ 1,567,575	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,279,882	\$ 5,758,795	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 843,362	\$ 843,362	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	69,657	69,657	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,343	2,343	31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,400	14,400	32
33	Accrued Interest Payable	15,837	15,837	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	57,273	57,273	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,002,872	\$ 1,002,872	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,098,002	3,098,002	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposit</u>	4,500	4,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,102,502	\$ 3,102,502	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,105,374	\$ 4,105,374	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,174,508	\$ 1,653,421	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,279,882	\$ 5,758,795	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,783,740	1
2	Restatements (describe):		2
3	2008 Bad Debt Allowance Entered After CR Completion	(20,000)	3
4	Rounding	(1)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,763,739	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	410,769	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)	\$ 410,769	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,174,508	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Robings Manor Rehab & Health Care**# **0026716**Report Period Beginning: **1/1/2009**Ending: **12/31/2009**

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,544,795	1
2	Discounts and Allowances for all Levels	(3,729)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,541,066	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	246,837	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 246,837	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	1,668	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	100,114	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	10,602	20
21	Other Medical Services	1,555	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 113,939	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,326	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,326	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	570	28
28a	Transportation Revenue	262	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 832	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,904,000	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	547,492	31
32	Health Care	1,060,713	32
33	General Administration	402,179	33
B. Capital Expense			
34	Ownership	299,880	34
C. Ancillary Expense			
35	Special Cost Centers	141,904	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)*	\$ 2,493,231	40
41	Income before Income Taxes (line 30 minus line 40)**	410,769	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 410,769	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 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:

1/1/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 53,795	\$ 25.86	1
2	Assistant Director of Nursing	2,168	2,168	43,595	20.11	2
3	Registered Nurses	3,721	3,822	84,918	22.22	3
4	Licensed Practical Nurses	10,855	11,231	207,140	18.44	4
5	CNAs & Orderlies	37,091	38,308	362,509	9.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	23,869	11.48	9
10	Activity Assistants					10
11	Social Service Workers	1652	1,652	16,725	10.12	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	26,084	12.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,538	10,797	86,574	8.02	15
16	Dishwashers					16
17	Maintenance Workers	2,064	2,064	28,001	13.57	17
18	Housekeepers	7,894	8,190	65,894	8.05	18
19	Laundry	6,338	6,485	51,073	7.88	19
20	Administrator	2,104	2,104	80,448	38.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,235	2,255	32,043	14.21	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 Restorative Aide	1,793	1,917	23,665	12.34	32
33	Other(specify) Transportation	9	9	98	10.89	33
34	TOTAL (lines 1 - 33)	94,702	97,242	\$ 1,186,431 *	\$ 12.20	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	20	\$ 1,038	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	600	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	20	\$ 16,038		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	152	\$ 7,366	10(3)	50
51	Licensed Practical Nurses	25	880	10(3)	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	177	\$ 8,246		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Susan Shaw	Administrator	0	\$ 80,000	Workers' Compensation Insurance	\$ 63,034	IDPH License Fee	\$ 1,990	
Brenda Lang	Administrator	0	448	Unemployment Compensation Insurance	18,023	Advertising: Employee Recruitment	363	
				FICA Taxes	84,635	Health Care Worker Background Check		
				Employee Health Insurance	100,592	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	92	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	342	
				Employee Relations	385	Miscellaneous Dues & Subscriptions	28	
				Employee Retirement	481	IHCA Dues	1,500	
				Employee Life Insurance		Home Office Allocation	1,490	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 80,448					
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
Description			Amount					
N/A			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$					
(Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description			Description	
Vendor/Payee	Type	Amount		Line #	Amount	Amount		
E-Health Data Solutions	Computer Services	\$ 2,700			\$	Out-of-State Travel		
LTC Solutions	Computer Services	1,700						
AT&T	Computer Services	490						
SimpleLTC, Inc.	Computer Services	81				In-State Travel		
						Seminar Expense		
						Home Office Allocation		
						122		
						Entertainment Expense		
						()		
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 4,971	\$			\$ 122	

* Attach copy of IMRF notifications

**See instructions.

Robings Manor Rehab & Health Care

0026716

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,971

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	34
GoffWilson, P.A.	Legal	49
Jackson Lewis	Legal	383
Peter Gartelos	Legal	37
Misc.	Legal	33
Ginoli & Company	Accountants	851
Miscellaneous Vendors	Computer Services	35
Emdeon Business Services	Computer Services	16
Advanced Answers on Demand	Computer Services	2,054
Access 2 Go	Computer Services	198
Ivans	Computer Services	23
Kemper Technology	Computer Services	558
VisionShare	Computer Services	174
MediFax	Computer Services	71
LogmeIn	Computer Services	31
Charter Communications	Computer Services	1
Simple LTC	Computer Services	474
Miscellaneous Vendors	Miscellaneous	324
Total (agree to Schedule V, line 19, column 8)		<u>10,317</u>

Facility Name & ID Number Robings Manor Rehab & Health Care# 0026716Report Period Beginning: 1/1/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 1,500 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 2,685 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 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? 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. \$ 1,668
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Robings Manor Rehab & Health Care
 0026716
 Period Beginning 1/1/2009
 Period End 12/31/2009

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	1,992	8.37%
Nursing Home	21,802	91.63%
	<u>23,794</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	129,309	8.37%	10,823	Census	1
Food	127,117	8.37%	10,640	Census	2
Housekeeping	83,539	8.37%	6,992	Census	3
Laundry	70,465	8.37%	5,898	Census	4
Utilities	78,711	8.37%	6,588	Census	5
Maintenance	58,351	8.37%	4,884	Census	6
Depreciation (Building)	<u>28,526</u>	100.00%	<u>28,526</u>	S/L Depr	30
Total	<u>576,018</u>		<u>74,351</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.