FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0026716

Facility Name: Robings Manor Rehab & Health Care

Address: 502 North Main (Number) Brighton (City) 62012 (Zip Code)

County: Macoupin

Telephone Number: (618) 372-3232 **Fax #** (618) 372-7117

HFS ID Number:

Date of Initial License for Current Owners: 01/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Larry Templin **Telephone Number:** (309) 689-5869
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mark B. Petersen

(Title) Chief Executive Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,268	1,268	8
9	SNF/PED					9
10	ICF	15,610	4,455	48	20,113	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,610	4,455	1,316	21,381	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.10%

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 [X] 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 [X]

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 1,268

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	119,386	17,093		136,479		136,479	(7,781)	128,698			1
2	Food Purchase		112,243		112,243		112,243	(11,493)	100,750			2
3	Housekeeping	67,748	20,481		88,229		88,229	(7,558)	80,671			3
4	Laundry	56,141	21,659		77,800		77,800	(6,706)	71,094			4
5	Heat and Other Utilities			79,073	79,073		79,073	(6,420)	72,653			5
6	Maintenance	26,468	13,536	31,963	71,967		71,967	(3,886)	68,081			6
7	Other (specify):* Home Off. Ben. All.							933	933			7
8	**TOTAL General Services**	269,743	185,012	111,036	565,791		565,791	(42,911)	522,880			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	794,756	30,187	3,368	828,311		828,311	(259)	828,052			10
10a	Therapy		73	174,474	174,547		174,547		174,547			10a
11	Activities	24,702	451	3,063	28,216		28,216		28,216			11
12	Social Services	21,317	21		21,338		21,338		21,338			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	840,775	30,732	195,305	1,066,812		1,066,812	(259)	1,066,553			16
	C. General Administration											
17	Administrative							84,679	84,679			17
18	Directors Fees											18
19	Professional Services			9,150	9,150		9,150	4,413	13,563			19
20	Dues, Fees, Subscriptions & Promotions			3,301	3,301		3,301	1,044	4,345			20
21	Clerical & General Office Expenses	35,100	3,686	8,411	47,197		47,197	39,450	86,647			21
22	Employee Benefits & Payroll Taxes			162,316	162,316		162,316		162,316			22
23	Inservice Training & Education			119	119		119	285	404			23
24	Travel and Seminar							33	33			24
25	Other Admin. Staff Transportation			4,567	4,567		4,567	3,567	8,134			25
26	Insurance-Prop.Liab.Malpractice			28,977	28,977		28,977	591	29,568			26
27	Other (specify):* Home Off. Ben. All.							16,176	16,176			27
28	**TOTAL General Administration**	35,100	3,686	216,841	255,627		255,627	150,238	405,865			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,145,618	219,430	523,182	1,888,230		1,888,230	107,068	1,995,298			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: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			102,154	102,154		102,154	(27,649)	74,505			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			169,511	169,511		169,511	2,373	171,884			32
33	Real Estate Taxes			16,151	16,151		16,151	122	16,273			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,222	6,222		6,222	547	6,769			35
36	Other (specify):*											36
37	TOTAL Ownership			294,038	294,038		294,038	(24,607)	269,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,354		75,354		75,354		75,354			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		106	29,939	30,045		30,045	(30,045)				43
44	TOTAL Special Cost Centers		75,460	71,002	146,462		146,462	(30,045)	116,417			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,145,618	294,890	888,222	2,328,730		2,328,730	52,416	2,381,146			45

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,818)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,439)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,711)	30		9
10	Interest and Other Investment Income	(2,187)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(108)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(42)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(14,483)	43		24
25	Fund Raising, Advertising and Promotional	(3,705)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(84,292)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,785)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	169,201	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 169,201		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 52,416		37

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

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

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

Robings Manor Rehab & Health Care

ID# 0026716

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (1,586)	43	1
2	X-Rays-Part A	(2,606)	43	2
3	Disallowed Special Events	75	43	3
4	Resident Flowers	(1,151)	43	4
5	Disallowed Dues	(49)	20	5
6	Independent Living Dietary Cost Offset	(11,764)	1	6
7	Independent Living Food Cost Offset	(9,675)	2	7
8	Independent Living Housekeeping Cost Offset	(7,605)	3	8
9	Independent Living Laundry Cost Offset	(6,706)	4	9
10	Independent Living Utilties Cost Offset	(6,816)	5	10
11	Indpendent Living Maintenance Cost Offset	(6,204)	6	11
12	Offset of Office Supplies Income	(188)	21	12
13	Interest Paid on Medicare Withholding	(727)	32	13
14	Indpendent Living Depreciation Offset	(28,526)	30	14
15	Offset of Nursing Supplies Income	(320)	10	15
16	Disallowed Real Estate Tax Late Fees	(444)	33	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**	(84,292)		49

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 B. 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. [X] 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%	$ 3,983	$ 3,983	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	47	47	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	396	396	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,318	2,318	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	933	933	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	61	61	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%	0		10
11	V	17	Administrative		Petersen Health Care, Inc.	100.00%	84,679	84,679	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	4,413	4,413	12
13	V								13
14	Total			$			$ 96,830	$ * 96,830	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: 1/1/2010 Ending: 12/31/2010

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. [X] 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)	
15	V	20	Dues, Fees, Subs and Promotions	$	Petersen Health Care, Inc.	100.00%	$ 1,093	$ 1,093	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	39,638	39,638	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	285	285	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	33	33	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,567	3,567	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	591	591	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	16,176	16,176	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	4,588	4,588	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,287	5,287	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	566	566	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%	547	547	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			$			$ 72,371	$ * 72,371	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: 1/1/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	179,534	0.82	1.36	Salary	$ 2,716	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 2,716		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: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,527,029	77	$ 284,427	$ 283,010	21,381	$ 3,983	1
2	2	Food	Resident Days	1,527,029	77	0	0	21,381	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	21,381	47	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	21,381	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	21,381	396	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	21,381	2,318	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	21,381	933	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	21,381	61	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	21,381	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	21,381	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	21,381	84,679	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	21,381	4,413	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	21,381	1,093	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	21,381	39,638	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	21,381	285	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	21,381	33	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	21,381	3,567	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	21,381	591	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	21,381	16,176	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	21,381	4,588	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	21,381	5,287	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	21,381	566	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	21,381	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	21,381	547	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 169,201	25

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America		X	Mortgage	Varies	1/17/07	$ 3,225,000	$ 3,046,893	12/31/13	Variable	$ 168,784	1
2												2
3							Interest Income Offset				(2,187)	3
4							Home Office Allocation-PHC				5,287	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,225,000	$ 3,046,893			$ 171,884	9
	B. Non-Facility Related*											
10							Interest Paid on Medicare Withholding				727	10
11							Interest Offset on Medicare Withholding Interest Paid				(727)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,225,000	$ 3,046,893			$ 171,884	15

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

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

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

Facility Name & ID Number Robings Manor Rehab & Health Care **#** 0026716 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 14,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2009	$ 14,807	2
3. Under or (over) accrual (line 2 minus line 1).		$ 407	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 15,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	**Home Office Allocation**	566	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 16,273	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	11,683	8
2006	12,573	9
2007	13,850	10
2008	14,028	11
2009	14,807	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-001-047-00	Lot 12, Albro Palmers etal sub div	$ 6,237.06	$ 6,237.06
2.	21-001-048-00	N Pt Lot 13 A Palmers etal sub div	$ 7,825.70	$ 7,825.70
3.	21-001-049-00	40 Ctr Lot 13 A Palmers etal sub div	$ 744.40	$ 744.70
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 14,807.16	$ 14,807.46

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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 Facility

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	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: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1977	1977	$ 340,200	$	25	$	$	$ 340,200	4
5	7		2006	2006	1,319,360		25	35,183	35,183	175,915	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			5,525	15
16	Various			1992	14,285		20	714	714	13,341	16
17	Various			1995	18,999		20	950	950	14,405	17
18	Tile flooring			1996	991		20	50	50	749	18
19	Curtains			1996	3,187		20	159	159	2,320	19
20	Mini blinds			1996	358		20	18	18	263	20
21	Concrete parking lot			1996	1,250		20	63	63	907	21
22	Paving and lining parking lot			1996	8,325		20	416	416	5,860	22
23	Electrical box			1997	3,777		20	189	189	2,646	23
24	Medicare survey			1997	1,543		20	77	77	1,040	24
25	Windows			1997	1,640		20	82	82	1,107	25
26	Screen patio			1997	8,369		20	418	418	5,574	26
27	Seal coat parking lot			1997	675		20	34	34	451	27
28	Landscaping			1998	4,553		15	304	304	3,694	28
29	Remodeling			1998	1,822		20	91	91	1,138	29
30	Siding & windows			1998	39,885		20	1,994	1,994	24,926	30
31	Outdoor sign			1999	1,036		20	52	52	624	31
32	Sprinkler heads			1999	2,187		20	109	109	1,309	32
33	Handicapped bathrooms			1999	23,785		20	1,189	1,189	12,973	33
34	Nurse call system			1999	3,648		20	182	182	2,185	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: 1/1/2010 Ending: 12/31/2010

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	
37	Roof	1999	21,735		20	1,087	$ 1,087	$ 13,044	37
38	Fencing	1999	2,777		20	139	139	1,668	38
39	Windows	1999	1,250		20	63	63	755	39
40	Garage & patio	1999	15,560		20	778	778	9,336	40
41	Windows	2000	1,233		20	62	62	650	41
42	Key system	2000	1,080		20	54	54	567	42
43	Resurface parking lot	2000	1,950		20	98	98	1,028	43
44	Kitchen remodeling	2001	2,152		20	108	108	1,025	44
45	Air compressor	2001	5,900		20	295	295	2,803	45
46	Carpet	2001	1,221		20	61	61	580	46
47	New roof - shed	2001	1,320		20	66	66	627	47
48	Remodel skilled units	2001	5,897		20	295	295	2,802	48
49	Building upgrades	2002	4,937		20	247	247	2,099	49
50	Nurses station cabinets	2002	2,369		20	118	118	1,004	50
51	Gutters and drains	2003	3,400		20	170	170	1,275	51
52	Hot water heater	2003	1,932		20	97	97	726	52
53	Boiler/Hot Water	2004	1,525		20	76	76	495	53
54	ADT Smoke detector	2004	6,176		20	309	309	2,008	54
55	Fire Suppression System	2004	1,920		20	96	96	624	55
56	Landscaping Improvements	2005	11,483		20	574	574	3,157	56
57	Architect Fees	2005	7,996		20	400	400	2,200	57
58	Fire System	2006	10,250		25	410	410	1,743	58
59	Generator	2006	5,260		15	351	351	1,579	59
60	Carpeting	2007	590		10	59	59	207	60
61	HVAC in Laundry Building	2007	6,900		15	460	460	1,610	61
62	Tile Replacement	2008	11,066		15	738	738	1,845	62
63	Sprinkler Installation on Outside Porch	2009	2,600		15	174	174	261	63
64									64
65	Land Improvements Booked			2,067			(2,067)		65
66	Building Improvement Booked			61,866			(61,866)		66
67	2010-Home Office Allocation-Building Improvements		10,277			246	246		67
68	2010-Home Office Allocation-Land Improvements		959			53	53		68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,062,374	$ 63,933		$ 49,958	$ (13,975)	$ 778,129	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: 1/1/2010 Ending: 12/31/2010

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	$ 212,560	$ 9,446	$ 21,256	$ 11,810	3-10 yrs.	$ 185,235	71
72	Current Year Purchases	2,984	249	149	(100)	10 yrs.	149	72
73	Fully Depreciated Assets	113,003					113,003	73
74	Home Office Allocation			3,142	3,142			74
75	TOTALS	$ 328,547	$ 9,695	$ 24,547	$ 14,852		$ 298,387	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)	$ 2,627,392	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 73,628	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 74,505	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 877	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,128,096	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	$ 123,950	86
87	Independent Living-2007	15,749	1,726	6,041	87
88					88
89					89
90					90
91	TOTALS	$ 685,749	$ 28,526	$ 129,991	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			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.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 6,769 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

* 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 1/1/2010
Period End 12/31/2010

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	$	1,958
Dishwasher		708
Copier		3,556
Home Office Allocation		547
		6,769

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

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.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			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.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	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	$	3,230	$ 48,456	$	3,230	$ 48,456	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,605	54,080		3,605	54,080	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		4,796	71,938	73	4,796	72,011	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				75,354		75,354	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			$	11,631	$ 174,474	$ 75,427	11,631	$ 249,901	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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 3,790,600	$ 3,790,600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 27,500)	78,035	78,035	3
4	Supply Inventory (priced at Cost)	10,964	10,964	4
5	Short-Term Investments			5
6	Prepaid Insurance	19,578	19,578	6
7	Other Prepaid Expenses			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)**	$ 4,962,745	$ 4,962,745	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	1,669,837	14
15	Leasehold Improvements, at Historical Cost	2,332,130	392,537	15
16	Equipment, at Historical Cost	401,426	380,127	16
17	Accumulated Depreciation (book methods)	(1,335,424)	(1,128,096)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,989,492	$ 1,499,296	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,952,237	$ 6,462,041	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 945,844	$ 945,844	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,690	73,690	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,789	12,789	31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,300	15,300	32
33	Accrued Interest Payable	14,844	14,844	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	29,018	29,018	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,091,485	$ 1,091,485	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,046,893	3,046,893	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposit	5,236	5,236	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,052,129	$ 3,052,129	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,143,614	$ 4,143,614	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,808,623	$ 2,318,427	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,952,237	$ 6,462,041	48

*(See instructions.)

Facility Name & ID Number Robings Manor Rehab & Health Care **#** 0026716 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,174,508	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,174,508	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	634,115	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)**	$ 634,115	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)**	$ 2,808,623	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,685,769	1
2	Discounts and Allowances for all Levels	(106,779)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,578,990	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	237,881	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 237,881	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	1,818	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	127,467	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	12,394	20
21	Other Medical Services	1,600	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 143,279	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,187	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,187	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	508	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 508	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,962,845	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	565,791	31
32	Health Care	1,066,812	32
33	General Administration	255,627	33
	B. Capital Expense		
34	Ownership	294,038	34
	C. Ancillary Expense		
35	Special Cost Centers	105,399	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)***	$ 2,328,730	40
41	**Income before Income Taxes (line 30 minus line 40)****	634,115	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 634,115	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: 1/1/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 55,409	$ 26.64	1
2	Assistant Director of Nursing	2,120	2,120	43,916	20.72	2
3	Registered Nurses	5,628	5,741	121,195	21.11	3
4	Licensed Practical Nurses	10,219	10,500	191,431	18.23	4
5	CNAs & Orderlies	35,874	37,102	358,633	9.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	24,702	11.88	9
10	Activity Assistants					10
11	Social Service Workers	2,056	2,056	21,317	10.37	11
12	Dietician					12
13	Food Service Supervisor	2,120	2,224	28,866	12.98	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,601	11,036	90,520	8.20	15
16	Dishwashers					16
17	Maintenance Workers	1,895	1,895	26,468	13.97	17
18	Housekeepers	7,717	7,969	67,748	8.50	18
19	Laundry	6,807	7,008	56,141	8.01	19
20	Administrator	2,080	2,080	81,963	39.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	35,100	16.88	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Restorative Aide	1,742	1,899	24,172	12.73	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	95,099	97,870	$ 1,227,581 *	$ 12.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	14,400	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,274	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 17,674		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	8	150	10(3)	52
53	TOTAL (lines 50 - 52)	8	$ 150		53

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Shaw	Administrator	0	$ 81,963
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 81,963

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 3,420
Mark Brueggemann	Legal Services	250
AT&T	Computer Services	480
Clifton Gunderson, LLP	Accounting Services	5,000
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 9,150

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,995
Unemployment Compensation Insurance	23,501
FICA Taxes	85,270
Employee Health Insurance	17,977
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,543
Employee Retirement	1,049
Life Insurance	(19)
TOTAL (agree to Schedule V, line 22, col.8)	$ 162,316

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,691
Health Care Worker Background Check	
(Indicate # of checks performed 89)	
Patient Background Checks	898
Miscellaneous Licenses & Permits	563
Miscellaneous Dues & Subscriptions	149
IHCA Dues	0
Home Office Allocation	1,093
Less: Public Relations Expense	(49)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,345

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	33
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 33

**See instructions.

Robings Manor Rehab & Health Care
0026716
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,150
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	4
Healthcare Resources International	Legal	54
Ginoli & Company	Accountants	780
Bank of America	Accountants	172
Miscellaneous Vendors	Computer Services	26
VisionShare	Computer Services	235
Advanced Answers on Demand	Computer Services	1,475
Access 2 Go	Computer Services	240
Kemper Technology	Computer Services	203
MediFax	Computer Services	84
Logmeln	Computer Services	60
Simple LTC	Computer Services	941
Optimizer Systems	Other Professional Fees	34
Clifton Gunderson	Other Professional Fees	105
Total (agree to Schedule V, line 19, column 8)		13,563

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Robings Manor Rehab & Health Care **#** 0026716 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **7,002** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **41,063**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** 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. $ **1,818**

(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? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
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? **Yes**
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

Period Beginning **1/1/2010**
Period End **12/31/2010**

Independent Living Offset

Schedule 23A

Census Days Summary:	**Days**	**%**
Independent Living	2,018	8.62%
Nursing Home	21,381	91.38%
	23,399	100.00%

Expense Offset:	**Total Amount**	**Ind. Liv %**	**Ind. Liv Offset**	**Basis For Allocation**	**Line**
Dietary	136,479	8.62%	11,764	Census	1
Food	112,243	8.62%	9,675	Census	2
Housekeeping	88,229	8.62%	7,605	Census	3
Laundry	77,800	8.62%	6,706	Census	4
Utilities	79,073	8.62%	6,816	Census	5
Maintenance	71,967	8.62%	6,204	Census	6
Depreciation (Building)	28,526	100.00%	28,526	Beds	30
Total	594,317		77,296		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was calculated based on total number of beds.
Independent Living overhead and depreciation cost have been offset on P5A.