

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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.

I. IDPH License ID Number: 0026716

Facility Name: Robings Manor Rehab & Health Care

Address: 502 North Main Street Brighton 62012
Number City 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

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

X

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

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 1/1/2011 to 12/31/2011
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)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed)
(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: 1/1/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			1,415	1,415	8
9	SNF/PED					9
10	ICF	15,622	4,760	22	20,404	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,622	4,760	1,437	21,819	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.70%

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 1,415

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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	116,154	14,945		131,099		131,099	(5,234)	125,865			1
2	Food Purchase		116,719		116,719		116,719	(11,454)	105,265			2
3	Housekeeping	68,359	18,667		87,026		87,026	(6,367)	80,659			3
4	Laundry	59,192	13,362		72,554		72,554	(5,333)	67,221			4
5	Heat and Other Utilities			77,747	77,747		77,747	(5,426)	72,321			5
6	Maintenance	27,833	4,245	22,771	54,849		54,849	(2,236)	52,613			6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,004	1,004			7
8	TOTAL General Services	271,538	167,938	100,518	539,994		539,994	(35,046)	504,948			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	816,203	42,996	3,841	863,040		863,040	44	863,084			10
10a	Therapy		120	244,202	244,322		244,322		244,322			10a
11	Activities	28,938	74	(450)	28,562		28,562	(2,923)	25,639			11
12	Social Services	19,314			19,314		19,314		19,314			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* <u>Home Off. Ben. All.</u>											15
16	TOTAL Health Care and Programs	864,455	43,190	260,793	1,168,438		1,168,438	(2,879)	1,165,559			16
	C. General Administration											
17	Administrative			98,400	98,400		98,400	(16,420)	81,980			17
18	Directors Fees											18
19	Professional Services			4,366	4,366		4,366	5,036	9,402			19
20	Dues, Fees, Subscriptions & Promotions			5,945	5,945		5,945	224	6,169			20
21	Clerical & General Office Expenses	36,603	3,132	9,104	48,839		48,839	40,661	89,500			21
22	Employee Benefits & Payroll Taxes			221,402	221,402		221,402		221,402			22
23	Inservice Training & Education							147	147			23
24	Travel and Seminar							43	43			24
25	Other Admin. Staff Transportation			5,969	5,969		5,969	3,771	9,740			25
26	Insurance-Prop.Liab.Malpractice			24,873	24,873		24,873	1,021	25,894			26
27	Other (specify):* <u>Home Off. Ben. All.</u>							16,679	16,679			27
28	TOTAL General Administration	36,603	3,132	370,059	409,794		409,794	51,162	460,956			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,172,596	214,260	731,370	2,118,226		2,118,226	13,237	2,131,463			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			106,997	106,997		106,997	(35,986)	71,011			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			167,897	167,897		167,897	4,424	172,321			32
33	Real Estate Taxes			15,275	15,275		15,275	363	15,638			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,520	10,520		10,520	643	11,163			35
36	Other (specify):*											36
37	TOTAL Ownership			300,689	300,689		300,689	(30,556)	270,133			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		72,235		72,235		72,235		72,235			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 Costs		54	63,476	63,530		63,530	(63,530)				43
44	TOTAL Special Cost Centers		72,289	104,539	176,828		176,828	(63,530)	113,298			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,172,596	286,549	1,136,598	2,595,743		2,595,743	(80,849)	2,514,894			45

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

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 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,895)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,992)	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	(13,356)	30		9
10	Interest and Other Investment Income	(2,672)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(194)	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	(805)	43		18
19	Entertainment				19
20	Contributions	(250)	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	(44,586)	43		24
25	Fund Raising, Advertising and Promotional	(5,051)	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 <u>See Page 5A</u>	(78,293)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (154,094)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	73,245	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 73,245		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (80,849)		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

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Labs-Part A	\$ (4,106)	43 1
2	X-Rays-Part A	(1,430)	43 2
3	Disallowed Special Events	(423)	43 3
4	Resident Flowers	(693)	43 4
5	Disallowed Chamber of Commerce Dues	(130)	20 5
6	Independent Living Dietary Cost Offset	(9,636)	1 6
7	Independent Living Food Cost Offset	(8,579)	2 7
8	Independent Living Housekeeping Cost Offset	(6,396)	3 8
9	Independent Living Laundry Cost Offset	(5,333)	4 9
10	Independent Living Utilities Cost Offset	(5,714)	5 10
11	Indpendent Living Maintenance Cost Offset	(4,031)	6 11
12	Offset of Office Supplies Income	(373)	21 12
13	Indpendent Living Depreciation Offset	(28,526)	30 13
14	Offset of Transportation Revenue	(2,923)	11 14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(78,293)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(9,636)	4,402	0	0	0	0	0	0	0	0	0	(5,234)	1
2	Food Purchase	(11,474)	20	0	0	0	0	0	0	0	0	0	(11,454)	2
3	Housekeeping	(6,396)	29	0	0	0	0	0	0	0	0	0	(6,367)	3
4	Laundry	(5,333)	0	0	0	0	0	0	0	0	0	0	(5,333)	4
5	Heat and Other Utilities	(5,714)	288	0	0	0	0	0	0	0	0	0	(5,426)	5
6	Maintenance	(4,031)	1,795	0	0	0	0	0	0	0	0	0	(2,236)	6
7	Other (specify):*	0	1,004	0	0	0	0	0	0	0	0	0	1,004	7
8	TOTAL General Services	(42,584)	7,538	0	0	0	0	0	0	0	0	0	(35,046)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	44	0	0	0	0	0	0	0	0	0	44	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,923)	0	0	0	0	0	0	0	0	0	0	(2,923)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,923)	44	0	0	0	0	0	0	0	0	0	(2,879)	16
	C. General Administration													
17	Administrative	0	(16,420)	0	0	0	0	0	0	0	0	0	(16,420)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	5,036	0	0	0	0	0	0	0	0	0	5,036	19
20	Fees, Subscriptions & Promotions	(130)	0	354	0	0	0	0	0	0	0	0	224	20
21	Clerical & General Office Expenses	(373)	0	41,034	0	0	0	0	0	0	0	0	40,661	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	147	0	0	0	0	0	0	0	0	147	23
24	Travel and Seminar	0	0	43	0	0	0	0	0	0	0	0	43	24
25	Other Admin. Staff Transportation	0	0	3,771	0	0	0	0	0	0	0	0	3,771	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,021	0	0	0	0	0	0	0	0	1,021	26
27	Other (specify):*	0	0	16,679	0	0	0	0	0	0	0	0	16,679	27
28	TOTAL General Administration	(503)	(11,384)	63,049	0	0	0	0	0	0	0	0	51,162	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(46,010)	(3,802)	63,049	0	0	0	0	0	0	0	0	13,237	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2011 Ending: 12/31/2011

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(41,882)	0	5,896	0	0	0	0	0	0	0	0	(35,986)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,672)	0	7,096	0	0	0	0	0	0	0	0	4,424	32
33	Real Estate Taxes	0	0	363	0	0	0	0	0	0	0	0	363	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	643	0	0	0	0	0	0	0	0	643	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(44,554)	0	13,998	0	0	0	0	0	0	0	0	(30,556)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(63,530)	0	0	0	0	0	0	0	0	0	0	(63,530)	43
44	TOTAL Special Cost Centers	(63,530)	0	0	0	0	0	0	0	0	0	0	(63,530)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(154,094)	(3,802)	77,047	0	0	0	0	0	0	0	0	(80,849)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as 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 PG6 - Supp		See PG6 - Supp		

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%	\$ 4,402	\$ 4,402	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	20	20	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	29	29	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	288	288	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	1,795	1,795	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,004	1,004	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	44	44	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	98,400	Petersen Health Care, Inc.	100.00%	81,980	(16,420)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	5,036	5,036	12
13	V								13
14	Total			\$ 98,400			\$ 94,598	\$ * (3,802)	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 & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 354	\$ 354	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	41,034	41,034	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	147	147	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	43	43	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,771	3,771	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,021	1,021	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	16,679	16,679	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	5,896	5,896	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	7,096	7,096	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	363	363	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	643	643	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			\$			\$ 77,047	\$ * 77,047	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:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo				1
2			Arcola Health Care Center	Arcola				2
3			Aspen Rehab & Health Care	Silvis				3
4			Batavia Rehab & Health Care Center	Batavia				4
5			Bement Health Care Center	Bement				5
6			Benton Rehab & Health Care Center	Benton				6
7			Bloomington Rehab & Health Care Center	Bloomington				7
8			Casey Health Care Center	Casey				8
9			Charleston Rehab & Health Care Center	Charleston				9
10			Cisne Rehab & Health Care Center	Cisne				10
11			Countryview Care Center of Macomb	Macomb				11
12			Countryview Terrace	Louisville				12
13			Cumberland Rehab & Health Care Center	Greenup				13
14			Decatur Rehab & Health Care Center	Decatur				14
15			Eastside Health & Rehabilitation Center	Pittsfield				15
16			Eastview Terrace	Sullivan				16
17			El Paso Health Care Center	El Paso				17
18			Enfield Rehab & Health Care Center	Enfield				18
19			Farmer City Rehab & Health Care Center	Farmer City				19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Robings Manor Rehab & Health Care

0026716

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

VII. RELATED PARTIES
A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Ozark Rehab & Health Care Center	Osage Beach, MO	Petersen Companies, LLC	Peoria	Mgmt/Bookkeeping	1
2			South Shore Health Care, LLC	Gary, IN	Petersen Health Care II, Inc.	Peoria	Mgmt/Bookkeeping	2
3			Cedargate Skilled Nursing Facility	Poplar Bluff, MO	Petersen Health Care, Inc.	Peoria	Mgmt/Bookkeeping	3
4			Tarkio Rehab & Health Care Center	Tarkio, MO	Petersen Health Enterprises, LLC	Peoria	Mgmt/Bookkeeping	4
5			Shangri-la Rehab & Living Center	Blue Springs, MO	Petersen Health Operations LLC	Peoria	Mgmt/Bookkeeping	5
6			Prairie Rose Care Center	Pana	Petersen Health Systems, Inc.	Peoria	Mgmt/Bookkeeping	6
7			Illini Heritage Rehab & Health Center	Champaign	Petersen Hotels LLC	Peoria	Hospitality	7
8			Courtyard Estates of Kewanee	Kewanee	Petersen Restaurants, LLC	Peoria	Restaurant	8
9			Courtyard Estates of Bradford	Bradford	Petersen Health Care IV, LLC	Peoria	Mgmt/Bookkeeping	9
10			Courtyard Estates of Galva	Galva	Petersen Health Care V, LLC	Peoria	Mgmt/Bookkeeping	10
11			Courtyard Estates of Walcott	Walcott	Petersen Health Care VI, LLC	Peoria	Mgmt/Bookkeeping	11
12			Courtyard Village of Kewanee	Kewanee	Petersen Health Care VII, LLC	Sullivan	Lessor	12
13			Lakewood Village	Charleston	Petersen Health Care VIII, LLC	Peoria	Mgmt/Bookkeeping	13
14			Courtyard Estates of Monmouth	Monmouth	Petersen Health Care X, LLC	Peoria	Lessor	14
15			Riverview Estates	Havana	Petersen Osage Beach, LLC	Osage Beach, MO	Lessor	15
16			Simple Blessings	Casey	Petersen West Frankfort, LLC	West Frankfort	Lessor	16
17			Courtyard Estates of Bushnell	Bushnell	Midwest Health Care, LLC	Peoria	Mgmt/Bookkeeping	17
18			Courtyard Estates of Canton	Canton	Poplar Bluff Health Care, LLC	Poplar Bluff, MO	Lessor	18
19			Legacy Estates of Monmouth	Monmouth	Petersen Roseville, LLC	Roseville	Lessor	19
20			Courtyard Estates of Sullivan	Sullivan				20
21			Courtyard Estates of Peoria	Peoria				21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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											1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	1,542,131	77	\$ 311,109	\$ 308,619	21,819	\$ 4,402	1
2	2	Food	Resident Days	1,542,131	77	1,436	0	21,819	20	2
3	3	Housekeeping	Resident Days	1,542,131	77	2,014	0	21,819	29	3
4	4	Laundry	Resident Days	1,542,131	77	0	0	21,819	0	4
5	5	Utilities	Resident Days	1,542,131	77	20,347	0	21,819	288	5
6	6	Maintenance	Resident Days	1,542,131	77	126,852	100,385	21,819	1,795	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	70,933	0	21,819	1,004	7
8	10	Nursing and Medical Records	Resident Days	1,542,131	77	3,130	0	21,819	44	8
9	10A	Therapy	Resident Days	1,542,131	77	0	0	21,819	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	0	0	21,819	0	10
11	17	Administrative	Resident Days	1,542,131	77	4,905,497	4,905,497	21,819	81,980	11
12	19	Professional Services	Resident Days	1,542,131	77	355,921	0	21,819	5,036	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,542,131	77	25,013	0	21,819	354	13
14	21	Clerical and General Office	Resident Days	1,542,131	77	2,900,214	2,467,442	21,819	41,034	14
15	23	Inservice Training & Education	Resident Days	1,542,131	77	10,374	0	21,819	147	15
16	24	Travel and Seminar	Resident Days	1,542,131	77	3,057	0	21,819	43	16
17	25	Other Admin. Staff Transport.	Resident Days	1,542,131	77	266,518	0	21,819	3,771	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,542,131	77	72,152	0	21,819	1,021	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,542,131	77	1,178,815	0	21,819	16,679	19
20	30	Depreciation	Resident Days	1,542,131	77	416,712	0	21,819	5,896	20
21	32	Interest	Resident Days	1,542,131	77	501,565	0	21,819	7,096	21
22	33	Real Estate Taxes	Resident Days	1,542,131	77	25,635	0	21,819	363	22
23	34	Rent-Facility and Grounds	Resident Days	1,542,131	77	0	0	21,819	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,542,131	77	45,440	0	21,819	643	24
25	TOTALS					\$ 11,242,734	\$ 7,781,943		\$ 171,645	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE												
A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)												
	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Bank of America		X	Mortgage	Varies	1/17/07	\$ 3,225,000	\$ 2,991,366	12/31/13	Variable	\$ 167,897	1
2												2
3								Interest Income Offset			(2,672)	3
4								Home Office Allocation-PHC			7,096	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 3,225,000	\$ 2,991,366			\$ 172,321	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 3,225,000	\$ 2,991,366			\$ 172,321	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.)

HFS 3745 (N-4-99)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	15,300	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.)		2010		\$	15,035	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(265)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	15,540	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.						
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			Home Office Allocation		363	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	15,638	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2006	12,573	8		
		2007	13,850	9		
		2008	14,028	10		
		2009	14,807	11		
		2010	15,035	12		
Accrual based on prior year tax bill.						

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2010 \$	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.

FACILITY NAME	<u>Robings Manor Rehab & Health Care</u>	COUNTY	<u>Macoupin</u>
---------------	--	--------	-----------------

COUNTY Macoupin

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet: 17,072
- B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1
- C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)
- D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)
- E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

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

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

XI. OWNERSHIP COSTS:

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:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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	211,098	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	14,055	16
17	Various			1995	18,999		20	950	950	15,355	17
18	Tile flooring			1996	991		20	50	50	799	18
19	Curtains			1996	3,187		20	159	159	2,479	19
20	Mini blinds			1996	358		20	18	18	281	20
21	Concrete parking lot			1996	1,250		20	63	63	970	21
22	Paving and lining parking lot			1996	8,325		20	416	416	6,276	22
23	Electrical box			1997	3,777		20	189	189	2,835	23
24	Medicare survey			1997	1,543		20	77	77	1,117	24
25	Windows			1997	1,640		20	82	82	1,189	25
26	Screen patio			1997	8,369		20	418	418	5,992	26
27	Seal coat parking lot			1997	675		20	34	34	485	27
28	Landscaping			1998	4,553		15	304	304	3,998	28
29	Remodeling			1998	1,822		20	91	91	1,229	29
30	Siding & windows			1998	39,885		20	1,994	1,994	26,920	30
31	Outdoor sign			1999	1,036		20	52	52	676	31
32	Sprinkler heads			1999	2,187		20	109	109	1,418	32
33	Handicapped bathrooms			1999	23,785		20	1,189	1,189	14,162	33
34	Nurse call system			1999	3,648		20	182	182	2,367	34
35											35
36											36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number Robings Manor Rehab & Health Care

0026716

Report Period Beginning:

1/1/2011

Ending:

12/31/2011

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Roof	1999	21,735		20	1,087	\$ 1,087	\$ 14,131	37
38 Fencing	1999	2,777		20	139	139	1,807	38
39 Windows	1999	1,250		20	63	63	818	39
40 Garage & patio	1999	15,560		20	778	778	10,114	40
41 Windows	2000	1,233		20	62	62	712	41
42 Key system	2000	1,080		20	54	54	621	42
43 Resurface parking lot	2000	1,950		20	98	98	1,126	43
44 Kitchen remodeling	2001	2,152		20	108	108	1,133	44
45 Air compressor	2001	5,900		20	295	295	3,098	45
46 Carpet	2001	1,221		20	61	61	641	46
47 New roof - shed	2001	1,320		20	66	66	693	47
48 Remodel skilled units	2001	5,897		20	295	295	3,097	48
49 Building upgrades	2002	4,937		20	247	247	2,346	49
50 Nurses station cabinets	2002	2,369		20	118	118	1,122	50
51 Gutters and drains	2003	3,400		20	170	170	1,445	51
52 Hot water heater	2003	1,932		20	97	97	823	52
53 Boiler/Hot Water	2004	1,525		20	76	76	571	53
54 ADT Smoke detector	2004	6,176		20	309	309	2,317	54
55 Fire Suppression System	2004	1,920		20	96	96	720	55
56 Landscaping Improvements	2005	11,483		20	574	574	3,731	56
57 Architect Fees	2005	7,996		20	400	400	2,600	57
58 Fire System	2006	10,250		25	410	410	2,153	58
59 Generator	2006	5,260		15	351	351	1,930	59
60 Carpeting	2007	590		10	59	59	266	60
61 HVAC in Laundry Building	2007	6,900		15	460	460	2,070	61
62 Tile Replacement	2008	11,066		15	738	738	2,583	62
63 Sprinkler Installation on Outside Porch	2009	2,600		15	174	174	435	63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,051,138	\$		\$ 49,659	\$ 49,659	\$ 827,788	70

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$		\$ 49,659	\$ 49,659	\$ 827,788	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Land Improvements Booked			1,783			(1,783)		8
9	Building Improvement Booked			61,178			(61,178)		9
10									10
11	2011-Home Office Allocation-Building Improvements		10,385			249	249		11
12	2011-Home Office Allocation-Land Improvements		969			62	62		12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,062,492	\$ 62,961		\$ 49,970	\$ (12,991)	\$ 827,788	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$215,544	\$8,353	\$10,925	\$2,572	5-10 yrs.	\$196,309	71
72	Current Year Purchases	6,236	643	312	(331)	10 yrs.	312	72
73	Fully Depreciated Assets	113,003					113,003	73
74	Home Office Allocation			5,896	5,896			74
75	TOTALS	\$334,783	\$8,996	\$17,133	\$8,137		\$309,624	75

D. Vehicle Costs. (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	Facility	2011 Ford E350 Van	2011	39,084	6,514	3,908	(2,606)	5 yrs.	3,908	78
79										79
80	TOTALS			\$90,664	\$6,514	\$3,908	\$(2,606)		\$55,488	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$2,672,83081
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$78,47182
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$71,01183
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(7,460)84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,192,90085

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	\$150,750	86
87	Independent Living-2007	15,749	1,726	7,767	87
88					88
89					89
90					90
91	TOTALS	\$685,749	\$28,526	\$158,517	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: \$ 11,163
- 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. /2012 \$

13. /2013 \$

14. /2014 \$

* 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 1/1/2011
Period End 12/31/2011

Schedule 14A

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

Medical Equipment	\$	4,275
Dishwasher		708
Laundry Equipment		-
Copier		5,537
Home Office Allocation		643
		<u>11,163</u>
		<u><u>11,163</u></u>

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? 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.	☐ YES ☒ NO	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.

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

	Service	Schedule V Line & Column Reference	2	3	4		6	7	8	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
					Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,093	\$ 91,399	\$	6,093	\$ 91,399	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,692	55,384		3,692	55,384	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		6,495	97,419	120	6,495	97,539	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				72,235		72,235	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			\$	16,280	\$ 244,202	\$ 72,355	16,280	\$ 316,557	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.

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	\$ 3,849,793	\$ 3,849,793	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	585,174	585,174	3
4	Supply Inventory (priced at Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,005	23,005	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)	\$ 5,532,504	\$ 5,532,504	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	1,669,945	14
15	Leasehold Improvements, at Historical Cost	2,332,130	392,547	15
16	Equipment, at Historical Cost	446,746	425,447	16
17	Accumulated Depreciation (book methods)	(1,442,421)	(1,192,900)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	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)	\$ 1,927,815	\$ 1,479,930	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 7,460,319	\$ 7,012,434	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 572,270	\$ 572,270	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,717	72,717	30
	Accrued Taxes Payable (excluding real estate taxes)	4,421	4,421	31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,540	15,540	32
33	Accrued Interest Payable	15,033	15,033	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	38,963	38,963	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 718,944	\$ 718,944	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,991,366	2,991,366	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposit	5,736	5,736	43
44	A/P-Other	490,293	490,293	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,487,395	\$ 3,487,395	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,206,339	\$ 4,206,339	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,253,980	\$ 2,806,095	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 7,460,319	\$ 7,012,434	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,808,623	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4	Prior Period Adjustment-Accrued Management Fees	(98,000)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,710,622	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	543,358	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)	\$ 543,358	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)	\$ 3,253,980	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number **Robings Manor Rehab & Health Care**# **0026716**Report Period Beginning: **1/1/2011**Ending: **12/31/2011**

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	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,791,179	1
2	Discounts and Allowances for all Levels	(149,516)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,641,663	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	354,412	6
7	Oxygen	404	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 354,816	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	2,895	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	119,378	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,111	20
21	Other Medical Services	5,270	21
22	Laundry	555	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 137,209	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,672	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,672	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	373	28
28a	Transportation Revenue	2,368	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,741	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,139,101	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	539,994	31
32	Health Care	1,168,438	32
33	General Administration	409,794	33
	B. Capital Expense		
34	Ownership	300,689	34
	C. Ancillary Expense		
35	Special Cost Centers	135,765	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)*	\$ 2,595,743	40
41	Income before Income Taxes (line 30 minus line 40)**	543,358	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 543,358	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.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,993	1,993	\$ 57,248	\$ 28.72	1
2	Assistant Director of Nursing	2,080	2,080	44,386	21.34	2
3	Registered Nurses	7,015	7,296	165,099	22.63	3
4	Licensed Practical Nurses	8,117	8,545	165,327	19.35	4
5	CNAs & Orderlies	36,224	37,097	359,197	9.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,163	2,163	26,352	12.18	9
10	Activity Assistants					10
11	Social Service Workers	1,812	1,812	19,314	10.66	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,040	30,600	15.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,816	10,067	85,554	8.50	15
16	Dishwashers					16
17	Maintenance Workers	1,888	1,936	27,833	14.38	17
18	Housekeepers	7,862	8,058	68,359	8.48	18
19	Laundry	6,834	7,093	59,192	8.35	19
20	Administrator	2,080	2,080	81,980	39.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,438	2,438	36,603	15.01	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	2,095	2,230	27,532	12.35	33
34	TOTAL (lines 1 - 33)	94,457	96,928	\$ 1,254,576 *	\$ 12.94	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	13,200	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,872	L10, C3	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) Psychologist	1	25	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1	\$ 17,097		49

C. CONTRACT NURSES

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

Robings Manor Rehab & Health Care

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Restorative Aide		1,782	1,917	24,946	13.01
Transportation		313	313	2,586	8.26
	TOTAL	2,095	2,230	27,532	

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	\$ 81,980	Workers' Compensation Insurance		\$ 48,207	IDPH License Fee	\$ 3,980
				Unemployment Compensation Insurance		22,828	Advertising: Employee Recruitment	431
				FICA Taxes		87,793	Health Care Worker Background Check	
				Employee Health Insurance		61,492	(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	91 916
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits	488
				Employee Relations		189	Miscellaneous Dues & Subscriptions	130
				Employee Retirement		893	Home Office Allocation	354
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
								</

*** Attach copy of IMRF notifications**

****See instructions.**

Robings Manor Rehab & Health Care
0026716
Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,366
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	5
Henry County Recorder	Legal	1
Ginoli & Company	Accountants	699
Miscellaneous Vendors	Computer Services	56
Advanced Answers on Demand	Computer Services	2,921
Access 2 Go	Computer Services	287
Kemper Technology	Computer Services	134
MediFax	Computer Services	45
VisionShare/Ability Network	Computer Services	206
Advanced System Design	Computer Services	269
Simple LTC	Computer Services	338
Optimizer Systems	Other Prof Fees	34
Clifton Gunderson	Other Prof Fees	12
Mike Miller	Other Prof Fees	16
OIC Group	Other Prof Fees	4
AllScripts	Other Prof Fees	9
Total (agree to Schedule V, line 19, column 8)		9,402

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	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>No</u> (2) Are there any dues to nursing home associations included on the cost report? <u>No</u> If YES, give association name and amount. _____ (3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? <u>N/A</u> (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? <u>N/A</u> (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10 yrs</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>8,176</u> Line <u>10</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. <u>N/A</u> (9) Are you presently operating under a sublease agreement? YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO <u>X</u> If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>N/A</u> (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>41,063</u> 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? <u>No</u> 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? <u>Yes</u> (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? <u>N/A</u> 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 benefit: on Schedule V. \$ <u>0</u> Has any meal income been offset against related costs? <u>Yes</u> Indicate the amount. \$ <u>2,895</u> (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>Yes</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ <u>2,368</u> c. What percent of all travel expense relates to transportation of nurses and patients? <u>N/A</u> d. Have vehicle usage logs been maintained? <u>Adequate records have been maintained.</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>Yes</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>N/A</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>N/A</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>Yes</u> Firm Name: <u>Ginoli & Company</u> (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? <u>Yes</u> (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? <u>N/A</u> Attach invoices and a summary of services for all architect and appraisal fees
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Robings Manor Rehab & Health Care

Period Beginning 1/1/2011
Period End 12/31/2011

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	1,731	7.35%
Nursing Home	21,819	92.65%
	23,550	100.00%

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	131,099	7.35%	9,636	Census	1
Food	116,719	7.35%	8,579	Census	2
Housekeeping	87,026	7.35%	6,396	Census	3
Laundry	72,554	7.35%	5,333	Census	4
Utilities	77,747	7.35%	5,714	Census	5
Maintenance	54,849	7.35%	4,031	Census	6
Depreciation (Building)	28,526	100.00%	28,526	Beds	30
Total	568,520		68,215		

Note: Computed overhead cost of Independent Living based on census days. Independent Living depreciation expense was actual depreciation on the building.
Independent Living overhead and depreciation costs have been offset on P5A.

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	116,154	14,945	0	131,099	0	131,099	-5,234	125,865
2. Food Purchase	0	116,719	0	116,719	0	116,719	-11,454	105,265
3. Housekeeping	68,359	18,667	0	87,026	0	87,026	-6,367	80,659
4. Laundry	59,192	13,362	0	72,554	0	72,554	-5,333	67,221
5. Heat and Other Utilities	0	0	77,747	77,747	0	77,747	-5,426	72,321
6. Maintenance	27,833	4,245	22,771	54,849	0	54,849	-2,236	52,613
7. Other (specify)*	0	0	0	0	0	0	1,004	1,004
8. Total General Services	271,538	167,938	100,518	539,994	0	539,994	-35,046	504,948
9. Medical Director	0	0	13,200	13,200	0	13,200	0	13,200
10. Nursing & Medical Records	816,203	42,996	3,841	863,040	0	863,040	44	863,084
10a. Therapy	0	120	244,202	244,322	0	244,322	0	244,322
11. Activities	28,938	74	-450	28,562	0	28,562	-2,923	25,639
12. Social Services	19,314	0	0	19,314	0	19,314	0	19,314
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	864,455	43,190	260,793	1,168,438	0	1,168,438	-2,879	1,165,559
17. Administrative	0	0	98,400	98,400	0	98,400	-16,420	81,980
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	4,366	4,366	0	4,366	5,036	9,402
20. Fees, Subscriptions & Promotion	0	0	5,945	5,945	0	5,945	224	6,169
21. Clerical & General Office	36,603	3,132	9,104	48,839	0	48,839	40,661	89,500
22. Employee Benefits & Payroll	0	0	221,402	221,402	0	221,402	0	221,402
23. Inservice Training & Education	0	0	0	0	0	0	147	147
24. Travel and Seminar	0	0	0	0	0	0	43	43
25. Other Admin. Staff Trans	0	0	5,969	5,969	0	5,969	3,771	9,740
26. Insurance-Prop.Liab.Malpractice	0	0	24,873	24,873	0	24,873	1,021	25,894
27. Other (specify)*	0	0	0	0	0	0	16,679	16,679
28. Total General Adminis	36,603	3,132	370,059	409,794	0	409,794	51,162	460,956
29. Total General Administrative	1,172,596	214,260	731,370	2,118,226	0	2,118,226	13,237	2,131,463
30. Depreciation	0	0	106,997	106,997	0	106,997	-35,986	71,011
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	167,897	167,897	0	167,897	4,424	172,321
33. Real Estate	0	0	15,275	15,275	0	15,275	363	15,638
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	10,520	10,520	0	10,520	643	11,163
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	300,689	300,689	0	300,689	-30,556	270,133
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	72,235	0	72,235	0	72,235	0	72,235
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Other (specify):*	0	0	41,063	41,063	0	41,063	0	41,063
43. Other (specify):*	0	54	63,476	63,530	0	63,530	-63,530	0
44. Total Special Cost Ce	0	72,289	104,539	176,828	0	176,828	-63,530	113,298
45. Grand Total	1,172,596	286,549	1,136,598	2,595,743	0	2,595,743	-80,849	2,514,894

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	3,849,793	3,849,793
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	585,174	585,174
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	23,005	23,005
7. Other Prepaid Expenses	10,964	10,964
8. Accounts Receivable-Owner/Related Party	1,063,568	1,063,568
9. Other (specify):	0	0
10. Total current assets	5,532,504	5,532,504
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	219,058	184,891
14. Buildings, at Historical Cost	372,302	1,669,945
15. Leasehold Improvements, Historical Cost	2,332,130	392,547
16. Equipment, at Historical Cost	446,746	425,447
17. Accumulated Depreciation (book methods)	-1,442,421	-1,192,900
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	1,927,815	1,479,930
25. Total Assets	7,460,319	7,012,434
CURRENT LIABILITIES		
26. Accounts Payable	572,270	572,270
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	72,717	72,717
31. Accrued Taxes Payable	4,421	4,421
32. Accrued Real Estate Taxes	15,540	15,540
33. Accrued Interest Payable	15,033	15,033
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	38,963	38,963
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	718,944	718,944
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	2,991,366	2,991,366
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	496,029	496,029
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	3,487,395	3,487,395
46.Total Liabilities	4,206,339	4,206,339
47.Total Equity	3,253,980	2,806,095
48.Total Liabilities and Equity	7,460,319	7,012,434

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,791,179
2. Discounts and Allowances for all Levels	-149,516
Subtotal - Inpatient Care	2,641,663
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	354,412
7. Oxygen	404
Subtotal - Anciliary Revenue	354,816
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	2,895
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	119,378
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	9,111
21. Other Medical Services	5,270
22. Laundry	555
Subtotal - Other Operating Revenue	137,209
24. Contributions	0
25. Interest and Other Investments Income	2,672
Subtotal - Non-Operating Revenue	2,672
27. Other Revenue (specify):	0
28. Other Revenue (specify):	2,741
Subtotal - Other Revenue	2,741
30. Total Revenue	3,139,101
31. General Services	539,994
32. Health Care	1,168,438
33. General Administration	409,794
34. Ownership	300,689
35. Special Cost Centers	135,765
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,595,743
41. Income Before Income Taxes	543,358
42. Income Taxes	0
43. Net Income or Loss for the Year	543,358