

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0053504

Facility Name: Robings Manor RHC

Address: 502 North Main St 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: 1/1/1977

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "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: Mike Kocher Telephone Number: (309) 689-5850
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 1/1/2016 to 12/31/2016 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 RHC

0053504 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

III. STATISTICAL DATA

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

N/A

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

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	<u>2,741</u>	<u>2,402</u>	<u>831</u>	<u>5,974</u>	8
9	SNF/PED					9
10	ICF	<u>15,695</u>			<u>15,695</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,436	2,402	831	21,669	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.16%

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 ☐

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 25 and days of care provided 761

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number **Robings Manor RHC** # **0053504** Report Period Beginning: **1/1/2016** Ending: **12/31/2016**
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	128,966	11,128		140,094		140,094	(465)	139,629			1
2	Food Purchase		130,126		130,126		130,126	(5,170)	124,956			2
3	Housekeeping	78,359	16,903		95,262		95,262	(3,265)	91,997			3
4	Laundry	58,231	13,731		71,962		71,962	(2,525)	69,437			4
5	Heat and Other Utilities			91,623	91,623		91,623	(2,956)	88,667			5
6	Maintenance	29,212	12,925	30,497	72,634		72,634	(119)	72,515			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	294,768	184,813	122,120	601,701		601,701	(14,500)	587,201			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	907,024	55,732	7,837	970,593		970,593	(824)	969,769			10
10a	Therapy			123,295	123,295		123,295		123,295			10a
11	Activities	39,936	517	225	40,678		40,678	(2,675)	38,003			11
12	Social Services	29,496			29,496		29,496		29,496			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	976,456	56,249	145,757	1,178,462		1,178,462	(3,499)	1,174,963			16
	C. General Administration											
17	Administrative			270,100	270,100		270,100	(178,493)	91,607			17
18	Directors Fees											18
19	Professional Services			9,394	9,394		9,394	23,232	32,626			19
20	Dues, Fees, Subscriptions & Promotions			5,343	5,343		5,343	409	5,752			20
21	Clerical & General Office Expenses	31,571	3,587	12,042	47,200		47,200	51,797	98,997			21
22	Employee Benefits & Payroll Taxes			161,982	161,982		161,982	29,014	190,996			22
23	Inservice Training & Education			150	150		150	99	249			23
24	Travel and Seminar							48	48			24
25	Other Admin. Staff Transportation			3,488	3,488		3,488	4,082	7,570			25
26	Insurance-Prop.Liab.Malpractice			24,068	24,068		24,068	575	24,643			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	31,571	3,587	486,567	521,725		521,725	(69,237)	452,488			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,302,795	244,649	754,444	2,301,888		2,301,888	(87,236)	2,214,652			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			4,219	4,219		4,219	67,400	71,619			30
31	Amortization of Pre-Op. & Org.							7,271	7,271			31
32	Interest							154,461	154,461			32
33	Real Estate Taxes			18,092	18,092		18,092	264	18,356			33
34	Rent-Facility & Grounds			161,829	161,829		161,829	(161,829)				34
35	Rent-Equipment & Vehicles			5,485	5,485		5,485	934	6,419			35
36	Other (specify):*											36
37	TOTAL Ownership			189,625	189,625		189,625	68,501	258,126			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,162		23,162		23,162		23,162			39
40	Barber and Beauty Shops			16	16		16		16			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			167,723	167,723		167,723		167,723			42
43	Other (specify):*		37	28,931	28,968		28,968	(28,968)				43
44	TOTAL Special Cost Centers		23,199	196,670	219,869		219,869	(28,968)	190,901			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,302,795	267,848	1,140,739	2,711,382		2,711,382	(47,703)	2,663,679			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	(685)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,287)	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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(40)	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	(27,350)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,604)	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	(54,974)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (91,940)		\$	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)	44,237	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 44,237		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (47,703)		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	Labs-Part A	\$ (1,118)	431
2	X-Rays-Part A	(856)	432
3	Indpendent Living Depreciation Offset	(27,878)	303
4	Disallowed Chamber of Commerce Dues	(65)	204
5	Independent Living Dietary Cost Offset	(4,916)	15
6	Independent Living Food Cost Offset	(4,566)	26
7	Independent Living Housekeeping Cost Offset	(3,343)	37
8	Independent Living Laundry Cost Offset	(2,525)	48
9	Independent Living Utilities Cost Offset	(3,215)	59
10	Indpendent Living Maintenance Cost Offset	(2,549)	610
11	Offset of Office Supplies Income	(92)	2111
12	Offset of Transportation Revenue	(2,675)	1112
13	Offset of Nursing Supplies Revenue	(956)	1013
14	Disallowed Special Events	(172)	4314
15	Disallowe Resident Flowers	(48)	4315
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	(54,974)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Robings Manor RHC# 0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	(4,916)	4,451	0	0	0	0	0	0	0	0	0	(465)	1
2	Food Purchase	(5,251)	81	0	0	0	0	0	0	0	0	0	(5,170)	2
3	Housekeeping	(3,343)	78	0	0	0	0	0	0	0	0	0	(3,265)	3
4	Laundry	(2,525)	0	0	0	0	0	0	0	0	0	0	(2,525)	4
5	Heat and Other Utilities	(3,215)	259	0	0	0	0	0	0	0	0	0	(2,956)	5
6	Maintenance	(2,549)	2,430	0	0	0	0	0	0	0	0	0	(119)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21,799)	7,299	0	0	0	0	0	0	0	0	0	(14,500)	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	(956)	132	0	0	0	0	0	0	0	0	0	(824)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(2,675)	0	0	0	0	0	0	0	0	0	0	(2,675)	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	(3,631)	132	0	0	0	0	0	0	0	0	0	(3,499)	16
	C. General Administration													
17	Administrative	0	(178,493)	0	0	0	0	0	0	0	0	0	(178,493)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,335	0	0	0	0	0	0	0	0	0	11,335	19
20	Fees, Subscriptions & Promotions	(65)	0	474	0	0	0	0	0	0	0	0	409	20
21	Clerical & General Office Expenses	(92)	0	51,889	11,897	0	0	0	0	0	0	0	63,694	21
22	Employee Benefits & Payroll Taxes	0	0	29,014	0	0	0	0	0	0	0	0	29,014	22
23	Inservice Training & Education	0	0	99	0	0	0	0	0	0	0	0	99	23
24	Travel and Seminar	0	0	48	0	0	0	0	0	0	0	0	48	24
25	Other Admin. Staff Transportation	0	0	4,082	0	0	0	0	0	0	0	0	4,082	25
26	Insurance-Prop.Liab.Malpractice	0	0	575	0	0	0	0	0	0	0	0	575	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(157)	(167,158)	86,181	11,897	0	0	0	0	0	0	0	(69,237)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(25,587)	(159,727)	86,181	11,897	0	0	0	0	0	0	0	(87,236)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Robings Manor RHC # 0053504 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(27,878)	0	11,482	0	93,303	0	0	0	0	0	0	76,907	30
31	Amortization of Pre-Op. & Org.	0	0	0	7,271	0	0	0	0	0	0	0	7,271	31
32	Interest	0	0	337	33,332	120,792	0	0	0	0	0	0	154,461	32
33	Real Estate Taxes	0	0	264	0	0	0	0	0	0	0	0	264	33
34	Rent-Facility & Grounds	0	0	0	0	(161,829)	0	0	0	0	0	0	(161,829)	34
35	Rent-Equipment & Vehicles	0	0	934	0	0	0	0	0	0	0	0	934	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(27,878)	0	13,017	40,603	52,266	0	0	0	0	0	0	78,008	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):*	(38,475)	0	0	0	0	0	0	0	0	0	0	(38,475)	43
44	TOTAL Special Cost Centers	(38,475)	0	0	0	0	0	0	0	0	0	0	(38,475)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(91,940)	(159,727)	99,198	52,500	52,266	0	0	0	0	0	0	(47,703)	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 Management, Inc.	100.00%	\$ 4,451	\$ 4,451	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	81	81	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	78	78	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	259	259	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	2,430	2,430	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	132	132	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	270,100	Petersen Health Care Management, Inc.	100.00%	91,607	(178,493)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	11,335	11,335	12
13	V								13
14	Total			\$ 270,100			\$ 110,373	\$ * (159,727)	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 Management, Inc.	100.00%	\$ 474	\$ 474	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	51,889	51,889	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	29,014	29,014	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	99	99	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	48	48	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	4,082	4,082	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	575	575	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	11,482	11,482	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	337	337	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	264	264	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	934	934	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			\$			\$ 99,198	\$ * 99,198	39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Business, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Business, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Business, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Business, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Business, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Business, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Business, LLC	100.00%	0		22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Business, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Business, LLC	100.00%	0		25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Business, LLC	100.00%	11,897	11,897	27
28	V	22	Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Business, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Business, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Business, LLC	100.00%	0		33
34	V	31	Amortization		Petersen Health Business, LLC	100.00%	7,271	7,271	34
35	V	32	Interest		Petersen Health Business, LLC	100.00%	33,332	33,332	35
36	V	33	Real Estate Taxes		Petersen Health Business, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0		38
39	Total			\$			\$ 52,500	\$ * 52,500	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation		Robings Land, LLC	100.00%	93,303	\$	93,303
16	V	32	Interest		Robings Land, LLC	100.00%	120,792		120,792
17	V	34	Rent-Facility and Grounds	161,829	Robings Land, LLC	100.00%			(161,829)
18	V								
19	V								
20	V								
21	V								
22	V								
23	V								
24	V								
25	V								
26	V								
27	V								
28	V								
29	V								
30	V								
31	V								
32	V								
33	V								
34	V								
35	V								
36	V								
37	V								
38	V								
39	Total			\$ 161,829			\$ 214,095	\$ *	52,266

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

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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 RHC

0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Palm Terrace of Mattoon	Mattoon				7
8			Piper City Rehab & Living Center	Piper City				8
9			Pleasant View Rehab & Health Care Center	Morrison				9
10			Polo Rehabilitation & Health Care Center	Polo				10
11			Prairie City Rehab & Health Care Center	Prairie City				11
12			Robings Manor Nursing Home	Brighton				12
13			Rochelle Gardens	Rochelle				13
14			Rochelle Rehab & Health Care Center	Rochelle				14
15			Rock Falls Rehab & Health Care Center	Rock Falls				15
16			Arrow Wood Independent Living	Rock Falls				16
17			Roseville Rehab and Health Care Center	Roseville				17
18			Rosiclare Rehab & Health Care Center	Rosiclare				18
19			Royal Oaks Care Center	Kewanee				19
20			Sandwich Rehab & Health Care Center	Sandwich				20
21			Iron Wood Independent Living	Sandwich				21
22			Shawnee Rose Care Center	Harrisburg				22
23			Shelbyville Rehab & Health Care Center	Shelbyville				23
24			South Elgin Rehab & Health Care Center	South Elgin				24
25			Sullivan Health Care Center	Sullivan				25
26			Sunset Manor Nursing Home	Canton				26
27			Swansea Rehab & Health Care	Swansea				27
28			Timbercreek Rehab & Health Center	Pekin				28
29			Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Twin Lakes Rehab & Health Care Center	Paris				1
2			Vandalia Rehab & Health Care Center	Vandalia				2
3			Watseka Health Care Center	Watseka				3
4			Westside Rehab & Care Center	West Frankfort				4
5			Whispering Oaks	Rosiclare				5
6			White Oak Rehab & Health Care Center	Mt. Vernon				6
7			Willow Rose Rehab & Health Care Center	Jerseyville				7
8			Sheldon Health Care Center	Sheldon				8
9			Tuscola Health Care Center	Tuscola				9
10			Effingham Health Care Center	Effingham				10
11			Collinsville Health Care Center	Collinsville				11
12			Ozark Rehab & Health Care Center	Osage Beach, MO				12
13			Tarkio Rehab & Health Care Center	Tarkio, MO				13
14			Shangri-la Rehab & Living Center	Blue Springs, MO				14
15			Prairie Rose Care Center	Pana				15
16			Illini Heritage Rehab & Health Center	Champaign				16
17			Courtyard Estates of Kewanee	Kewanee				17
18			Courtyard Estates of Bradford	Bradford				18
19			Courtyard Estates of Galva	Galva				19
20			Courtyard Estates of Walcott	Walcott				20
21			Courtyard Village of Kewanee	Kewanee				21
22			Lakewood Village	Charleston				22
23			Courtyard Estates of Monmouth	Monmouth				23
24			Riverview Estates	Havana				24
25			Simple Blessings	Casey				25
26			Courtyard Estates of Bushnell	Bushnell				26
27			Courtyard Estates of Canton	Canton				27
28			Legacy Estates of Monmouth	Monmouth				28
29			Courtyard Estates of Sullivan	Sullivan				29
30			Courtyard Estates of Peoria	Peoria				30

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Robings Manor RHC # 0053504 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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	N/A										3
4											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

Facility Name & ID Number Robings Manor RHC# 0053504

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e., Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	75	\$ 312,540	\$ 357,910	21,669	\$ 4,451	1
2	2	Food	Resident Days	75	5,673	0	21,669	81	2
3	3	Housekeeping	Resident Days	75	5,456	2,897	21,669	78	3
4	5	Utilities	Resident Days	75	18,209	0	21,669	259	4
5	6	Maintenance	Resident Days	75	170,632	137,057	21,669	2,430	5
6	7	Mgmt. Allocation of Benefits	Resident Days	75	0	0	21,669	0	6
7	9	Medical Director	Resident Days	75	0	0	21,669	0	7
8	10	Nursing and Medical Records	Resident Days	75	9,261	1,782,521	21,669	132	8
9	10A	Therapy	Resident Days	75	0	0	21,669	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	75	0	0	21,669	0	10
11	17	Administrative	Resident Days	75	4,806,228	5,473,961	21,669	91,607	11
12	19	Professional Services	Resident Days	75	795,918	0	21,669	11,335	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	75	33,278	0	21,669	474	13
14	21	Clerical and General Office	Resident Days	75	3,643,535	3,756,135	21,669	51,889	14
15	22	Employee Benefits and Payroll Tax	Resident Days	75	2,037,314	0	21,669	29,014	15
16	23	Inservice Training & Education	Resident Days	75	6,986	0	21,669	99	16
17	24	Travel and Seminar	Resident Days	75	3,389	0	21,669	48	17
18	25	Other Admin. Staff Transport.	Resident Days	75	286,637	0	21,669	4,082	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	75	40,378	0	21,669	575	19
20	27	Mgmt. Allocation of Benefits	Resident Days	75	0	0	21,669	0	20
21	30	Depreciation	Resident Days	75	806,271	0	21,669	11,482	21
22	32	Interest	Resident Days	75	23,686	0	21,669	337	22
23	33	Real Estate Taxes	Resident Days	75	18,560	0	21,669	264	23
24	35	Rent-Equipment & Vehicles	Resident Days	75	65,550	0	21,669	934	24
25	TOTALS				\$ 13,089,501	\$ 11,510,481		\$ 209,571	25

Facility Name & ID Number Robings Manor RHC# 0053504

Report Period Beginning:

1/1/2016Ending: 2/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen Health Business, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	171,230	9	\$	\$	21,669	\$	1
2	2	Food	Resident Days	171,230	9			21,669		2
3	3	Housekeeping	Resident Days	171,230	9			21,669		3
4	4	Laundry	Resident Days	171,230	9			21,669		4
5	5	Utilities	Resident Days	171,230	9			21,669		5
6	6	Maintenance	Resident Days	171,230	9			21,669		6
7	7	Mgmt. Allocation of Benefits	Resident Days	171,230	9			21,669		7
8	10	Nursing and Medical Records	Resident Days	171,230	9			21,669		8
9	15	Mgmt. Allocation of Benefits	Resident Days	171,230	9			21,669		9
10	17	Administrative	Resident Days	171,230	9			21,669		10
11	19	Professional Services	Resident Days	171,230	9			21,669		11
12	20	Dues, Fees, Subs & Promotions	Resident Days	171,230	9			21,669		12
13	21	Clerical and General Office	Resident Days	171,230	9	90,714		21,669	11,897	13
14	22	Employee Benefits & Payroll	Resident Days	171,230	9			21,669		14
15	23	Inservice Training & Education	Resident Days	171,230	9			21,669		15
16	24	Travel and Seminar	Resident Days	171,230	9			21,669		16
17	25	Other Admin. Staff Transport.	Resident Days	171,230	9			21,669		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	171,230	9			21,669		18
19	30	Depreciation	Resident Days	171,230	9			21,669		19
20	31	Amortization	Resident Days	171,230	9	55,441		21,669	7,271	20
21	32	Interest	Resident Days	171,230	9	254,149		21,669	33,332	21
22	33	Real Estate Taxes	Resident Days	171,230	9			21,669		22
23	34	Rent-Facility and Grounds	Resident Days	171,230	9			21,669		23
24	35	Rent-Equipment & Vehicles	Resident Days	171,230	9			21,669		24
25	TOTALS					\$ 400,304	\$		\$ 52,500	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 Leumi		X	Mortgage	Varies	1/1/2015	3,325,000	\$ 2,352,551	12/31/24	Variable	\$ 120,792	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 3,325,000	\$ 2,352,551			\$ 120,792	9	
	B. Non-Facility Related*												
10												10	
11								Home Office Allocation-PHB			33,332	11	
12								Home Office Allocation-PHCM			337	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 33,669	14	
15	TOTALS (line 9+line14)						\$ 3,325,000	\$ 2,352,551			\$ 154,461	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ 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.)

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.																																	
1. Real Estate Tax accrual used on 2015 report.			\$	16,908	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.)			\$	17,240	2																														
3. Under or (over) accrual (line 2 minus line 1).			\$	332	3																														
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	17,760	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.)			\$	264	6																														
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	18,356	7																														
Real Estate Tax History:																																			
Real Estate Tax Bill for Calendar Year:		<table><tr><td>2011</td><td>15,225</td><td>8</td></tr><tr><td>2012</td><td>15,705</td><td>9</td></tr><tr><td>2013</td><td>16,032</td><td>10</td></tr><tr><td>2014</td><td>16,411</td><td>11</td></tr><tr><td>2015</td><td>17,240</td><td>12</td></tr></table>	2011	15,225	8	2012	15,705	9	2013	16,032	10	2014	16,411	11	2015	17,240	12	<table><tr><td></td><td>FOR BHF USE ONLY</td><td></td></tr><tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2015 \$</td><td>13</td></tr><tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr><tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr><tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr></table>				FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2015 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2011	15,225	8																																	
2012	15,705	9																																	
2013	16,032	10																																	
2014	16,411	11																																	
2015	17,240	12																																	
	FOR BHF USE ONLY																																		
13	FROM R. E. TAX STATEMENT FOR 2015 \$	13																																	
14	PLUS APPEAL COST FROM LINE 5 \$	14																																	
15	LESS REFUND FROM LINE 6 \$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																																	
Accrual based on prior year tax bill.																																			

- 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Robings Manor RHC COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0053504

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 21-001-047-00	Lot 12, Albro Palmers etal sub div	\$ 7,236.30	\$ 7,236.30
2. 21-001-048-00	N Pt Lot 13 A Palmers etal sub div	\$ 9,079.50	\$ 9,079.50
3. 21-001-049-00	40 Ctr Lot 13 A Palmers etal sub div	\$ 924.48	\$ 924.48
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 17,240.28	\$ 17,240.28

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet:

17,072

B. General Construction Type:

Exterior

Brick

Frame

Wood

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Independent Living Facilities

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:

95,556

2. Number of Years Over Which it is Being Amortized:

20

3. Current Period Amortization:

7,271

4. Dates Incurred:

2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	42,108	1977	\$ 25,000	1
2	Facility	18,797	2003	159,891	2
3	TOTALS	60,905		\$ 184,891	3

Facility Name & ID Number Robings Manor RHC

0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	387,013	5
6											6
7											7
8											8
	Improvement Type**										
9	1978-1992 Fully Depreciated Assets				125,069					125,069	9
10	Various			1995	18,999		20	794	794	18,999	10
11	Tile flooring			1996	991		20	42	42	991	11
12	Curtains			1996	3,187		20	72	72	3,187	12
13	Mini blinds			1996	358		20	5	5	358	13
14	Concrete parking lot			1996	1,250		20	28	28	1,250	14
15	Paving and lining parking lot			1996	8,325		20	385	385	8,325	15
16	Electrical box			1997	3,777		20	186	186	3,777	16
17	Medicare survey			1997	1,543		20	77	77	1,502	17
18	Windows			1997	1,640		20	82	82	1,599	18
19	Screen patio			1997	8,369		20	418	418	8,082	19
20	Seal coat parking lot			1997	675		20	34	34	655	20
21	Landscaping			1998	4,553		15			4,553	21
22	Remodeling			1998	1,822		20	91	91	1,684	22
23	Siding & windows			1998	39,885		20	1,994	1,994	36,890	23
24	Outdoor sign			1999	1,036		20	52	52	936	24
25	Sprinkler heads			1999	2,187		20	109	109	1,963	25
26	Handicapped bathrooms			1999	23,785		20	1,189	1,189	20,107	26
27	Nurse call system			1999	3,648		20	182	182	3,277	27
28	Roof			1999	21,735		20	1,087	1,087	19,566	28
29	Fencing			1999	2,777		20	139	139	2,502	29
30	Windows			1999	1,250		20	63	63	1,133	30
31	Garage & patio			1999	15,560		20	778	778	14,004	31
32	Windows			2000	1,233		20	62	62	1,022	32
33	Key system			2000	1,080		20	54	54	891	33
34	Resurface parking lot			2000	1,950		20	98	98	1,616	34
35	Kitchen remodeling			2001	2,152		20	108	108	1,673	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 RHC

0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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 Air compressor	2001	5,900		20	295	\$ 295	\$ 4,573	37
38 Carpet	2001	1,221		20	61	61	946	38
39 New roof - shed	2001	1,320		20	66	66	1,023	39
40 Remodel skilled units	2001	5,897		20	295	295	4,572	40
41 Building upgrades	2002	4,937		20	247	247	3,581	41
42 Nurses station cabinets	2002	2,369		20	118	118	1,712	42
43 Gutters and drains	2003	3,400		20	170	170	2,295	43
44 Hot water heater	2003	1,932		20	97	97	1,308	44
45 Boiler/Hot Water	2004	1,525		20	76	76	951	45
46 ADT Smoke detector	2004	6,176		20	309	309	3,862	46
47 Fire Suppression System	2004	1,920		20	96	96	1,200	47
48 Landscaping Improvements	2005	11,483		20	574	574	6,601	48
49 Architect Fees	2005	7,996		20	400	400	4,600	49
50 Fire System	2006	10,250		25	410	410	4,203	50
51 Generator	2006	5,260		15	351	351	3,685	51
52 Carpeting	2007	590		10	59	59	561	52
53 HVAC in Laundry Building	2007	6,900		15	460	460	4,370	53
54 Tile Replacement	2008	11,066		15	738	738	6,273	54
55 Sprinkler Installation on Outside Porch	2009	2,600		15	174	174	1,305	55
56 Dry Pressure Valve Repair	2013	2,861		7	408	408	1,428	56
57 Generator Repair	2013	4,240		7	606	606	2,121	57
58 Sprinkler System Repair	2013	10,199		7	1,458	1,458	5,103	58
59 Hall 200 Remodeling	2014	4,945		15	330	330	825	59
60 Flooring for Front Entry Area	2014	6,893		15	460	460	1,150	60
61 Water Heater	2015	4,300		7	614	614	921	61
62 Door Alarm System	2015	3,961		7	576	576	859	62
63 Door for Hall 200	2016	3,523		7	252	252	252	63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,092,060	\$		\$ 53,012	\$ 53,012	\$ 1,083,104	70

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

Facility Name & ID Number Robings Manor RHC

0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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		\$ 2,092,060	\$		\$ 53,012	\$ 53,012	\$ 1,083,104	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28	Land Improvements Booked			1,102			(1,102)		28
29	Building Improvement Booked			90,843			(90,843)		29
30									30
31	2016-Home Office Allocation-Building Improvements		9,567			230	230		31
32	2016-Home Office Allocation-Land Improvements		880			57	57		32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,102,507	\$ 91,945		\$ 53,299	\$ (38,646)	\$ 1,083,104	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	\$38,889	\$4,274	\$3,215	\$ (1,059)	5-10 yrs.	\$20,829	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	159,109					159,109	73
74	Home Office Allocation			11,195	11,195			74
75	TOTALS	\$197,998	\$4,274	\$14,410	\$10,136		\$179,938	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	2011 Ford E350 Van	2011	39,084	\$1,303	\$3,910	\$2,607		\$39,084	76
77										77
78										78
79										79
80	TOTALS			\$39,084	\$1,303	\$3,910	\$2,607		\$39,084	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)	\$2,524,480	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$97,522	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$71,619	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(25,903)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,302,126	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	\$284,750	86
87	Independent Living-2007	15,749	1,078	15,749	87
88					88
89					89
90					90
91	TOTALS	\$685,749	\$27,878	\$300,499	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94	N/A		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 RHC	#	0053504	Report Period Beginning:	1/1/2016	Ending:	12/31/2016
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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: \$ **6,419** Description: **See Attached Schedule 14A**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	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. 2017 \$

13. /2018 \$

14. /2019 \$

*** 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 RHC
0053504
Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

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

Medical Equipment	\$	2,107
Dishwasher		701
Copier		2,677
Home Office Allocation		934
		<u>6,419</u>

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

☒ NO

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.

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	\$	2,893	\$ 43,389	\$	2,893	\$ 43,389	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,990	29,852		1,990	29,852	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		3,337	50,054		3,337	50,054	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				23,162		23,162	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	8,220	\$ 123,295	\$ 23,162	8,220	\$ 146,457	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	\$ 3,112,127	\$ 3,112,127	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 68,359)	1,179,273	1,179,273	3
4	Supply Inventory (priced at Cost)	10,964	10,964	4
5	Short-Term Investments			5
6	Prepaid Insurance	24,328	24,328	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	1,025	1,025	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,327,717	\$ 4,327,717	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		184,891	13
14	Buildings, at Historical Cost		1,669,127	14
15	Leasehold Improvements, at Historical Cost	11,784	433,380	15
16	Equipment, at Historical Cost	45,820	237,082	16
17	Accumulated Depreciation (book methods)	(42,837)	(1,302,126)	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): Independent Living Facility		385,250	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 14,767	\$ 1,607,604	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,342,484	\$ 5,935,321	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 512,588	\$ 512,588	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,236	6,236	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	74,887	74,887	30
31	Accrued Taxes Payable (excluding real estate taxes)	109,553	109,553	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,760	17,760	32
33	Accrued Interest Payable		10,130	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	300,555	300,555	36
37	Accrued Management Fees	444,203	444,203	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,465,782	\$ 1,475,912	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,352,551	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Loans	6,958,060	6,958,060	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,958,060	\$ 9,310,611	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 8,423,842	\$ 10,786,523	46
47	TOTAL EQUITY(page 18, line 24)	\$ (4,081,358)	\$ (4,851,202)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,342,484	\$ 5,935,321	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,406,230)	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	839,189	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (4,567,041)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	485,683	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)	\$ 485,683	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)	\$ (4,081,358)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Robings Manor RHC

0053504

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,972,319	1
2	Discounts and Allowances for all Levels	(74,519)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,897,800	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	38,012	5
6	Therapy	210,404	6
7	Oxygen	251	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 248,667	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	685	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	41,206	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,832	20
21	Other Medical Services	3,152	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 46,875	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,675	28
28a	<u>Miscellaneous Revenue</u>	1,048	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,723	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,197,065	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	601,701	31
32	Health Care	1,178,462	32
33	General Administration	521,725	33
	B. Capital Expense		
34	Ownership	189,625	34
	C. Ancillary Expense		
35	Special Cost Centers	52,146	35
36	Provider Participation Fee	167,723	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,711,382	40
41	Income before Income Taxes (line 30 minus line 40)**	485,683	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 485,683	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,190,287	44
45	Private Pay - Net Inpatient Revenue	524,565	45
46	Medicare - Net Inpatient Revenue	170,245	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	12,703	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,897,800	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** 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	2,551	2,631	\$ 75,254	\$ 28.60	1
2	Assistant Director of Nursing	2,080	2,080	51,456	24.74	2
3	Registered Nurses	8,925	9,093	202,986	22.32	3
4	Licensed Practical Nurses	9,099	9,398	153,712	16.36	4
5	CNAs & Orderlies	30,139	30,894	394,282	12.76	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,112	26,480	12.54	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	29,496	14.18	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,722	14.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,368	10,724	99,244	9.25	15
16	Dishwashers					16
17	Maintenance Workers	1,713	1,804	29,212	16.19	17
18	Housekeepers	8,128	8,455	78,359	9.27	18
19	Laundry	6,599	6,792	58,231	8.57	19
20	Administrator	2,080	2,080	91,607	44.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,108	2,108	31,571	14.98	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Restorative Aides	1,804	1,962	29,334	14.95	32
33	Other(specify) Transportation	1,467	1,467	13,456	9.17	33
34	TOTAL (lines 1 - 33)	93,301	95,760	\$ 1,394,402 *	\$ 14.56	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	14,400	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,807	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	6	384	L10, C3	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)	6	\$ 19,591		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

STATE OF ILLINOIS

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

Page 21

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	\$ 91,607	Workers' Compensation Insurance		\$ 28,087	IDPH License Fee		\$ 1,990	
					Unemployment Compensation Insurance		35,298	Advertising: Employee Recruitment		378	
					FICA Taxes		92,631	Health Care Worker Background Check			
					Employee Health Insurance		4,821	(Indicate # of checks performed 12)		391	
					Employee Meals			Patient Background Checks		33 391	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		1,018	
					Employee Relations		861	Miscellaneous Dues & Subscriptions		1,175	
					Employee Retirement		284	Home Office Allocation		474	
					Home Office Allocation		29,014				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 91,607							
B. Administrative - Other								Less: Public Relations Expense		()	
Description				Amount				Non-allowable advertising		(65)	
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 270,100				Yellow page advertising		()	
					TOTAL (agree to Schedule V, line 22, col.8)		\$ 190,996	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 5,752	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 270,100	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**		
C. Professional Services				Amount	Description		Line #	Amount	Description		Amount
Vendor/Payee		Type							Out-of-State Travel		\$
E-Health Data Solutions		Computer Services		\$ 2,940							
AT&T		Computer Services		1,000							
Honkamp Krueger & Company		Accounting Fees		94	N/A						
Ability Network		Computer Services		102					In-State Travel		
Boyle Brashers LLC		Legal Fees		4,258							
Law Offices of Muller and Haller		Legal Fees		1,000							
									Seminar Expense		
									Home Office Allocation		48
									Entertainment Expense		()
									(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 9,394	TOTAL		\$		TOTAL		\$ 48

* Attach copy of IMRF notifications

**See instructions.

Robings Manor RHC
0053504
Period Beginning
Period End

1/1/2016
12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,394
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	51
Miscellaneous	Legal	17
Miller Hall and Triggs	Legal	88
Healthcare Resources International	Legal	437
Hunziker Law	Legal	104
Lexis Nexis	Legal	9
Illinois Secretary of State	Legal	66
Chicago Title Insurance	Legal	3,047
Bank Leumi	Legal	925
CliftonLarson Allen	Accountants	454
Ginoli & Co.	Accountants	3,967
Miscellaneous	Computer Services	58
Change Healthcare	Computer Services	8
PTC Select	Computer Services	5
Advanced Answers on Demand	Computer Services	3,990
Stratus Networks	Computer Services	406
Kemper Technology	Computer Services	267
AT&T	Computer Services	6
Ability Network	Computer Services	1,701
CIAN	Computer Services	203
Comcast	Computer Services	33
CCH	Computer Services	13
Charter Communications	Computer Services	39
Allscripts	Computer Services	593
ATS	Computer Services	268
Allpayer Exchange	Computer Services	14
Optimizer	Other Prof Fees	41
Ankura	Other Prof Fees	310
David Budde	Other Prof Fees	35
Bruner, Cooper, Zuck	Other Prof Fees	90
Marotta, Gund, Budd, Dzerda	Other Prof Fees	5,935
Professional Software and Services	Other Prof Fees	22
Hughes Valuation Services	Other Prof Fees	28
Alan Litwiller	Other Prof Fees	2

Total (agree to Schedule V, line 19, column 8)	<u><u>32,626</u></u>
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Robings Manor Rehab & Health Care
0053504

Period Beginning 1/1/2016

Period End 12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE

Legal Fees

Home Office Allocation-PHC & PHCM

Lucie, Scalf, and Bougher	Legal	51
Miscellaneous	Legal	17
Miller Hall and Triggs	Legal	88
Healthcare Resources International	Legal	437
Hunziker Law	Legal	104
Lexis Nexis	Legal	9
Illinois Secretary of State	Legal	66
Chicago Title Insurance	Legal	3,047
Bank Leumi	Legal	925

Direct Facility Invoices

Boyle Brashers LLC	2/11/2016	3,350
Law Offices of Mueller and Haller	4/25/2016	1,000
Boyle Brashers LLC	5/10/2016	908

Total Legal Fees (agree to Schedule V, line 19, column 8)	<u>10,001</u>
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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

No

(2) Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount. IHCA-\$1,000

(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?

7 yrs.

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 8,698

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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 167,723

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

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

Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.

\$ 0

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 685

(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.

\$ 2,675

c. What percent of all travel expense relates to transportation of nurses and patients?

100

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?

Yes

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A

(17) Has an audit been performed by an independent certified public accounting firm?

Yes

Firm Name:

Ginoli and Company

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility?

See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees

Robings Manor Rehab & Health Care
0053504
Period Beginning 1/1/2016
Period End 12/31/2016

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	788	3.51%
Nursing Home	21,669	96.49%
	22,457	100.00%

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	140,094	3.51%	4,916	Census	1
Food	130,126	3.51%	4,566	Census	2
Housekeeping	95,262	3.51%	3,343	Census	3
Laundry	71,962	3.51%	2,525	Census	4
Utilities	91,623	3.51%	3,215	Census	5
Maintenance	72,634	3.51%	2,549	Census	6
Depreciation (Building)	27,878	100.00%	27,878	Beds	30
Total	629,579		48,991		

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 costs have been offset on P5A.

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Det	-47,703	equal to	-47,703	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	154,461	equal to	154,461	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	18,356	equal to	18,356	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	7,271	equal to	7,271	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	71,619	equal to	71,619	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	6,419	equal to	6,419	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	123,295	equal to	123,295	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	23,162	equal to	23,162	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	601,701	equal to	601,701	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	1,178,462	equal to	1,178,462	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	521,725	equal to	521,725	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	189,625	equal to	189,625	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	52,146	equal to	52,146	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pr	167,723	equal to	167,723	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	907,024	equal to	907,024	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aidi	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	39,936	equal to	39,936	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	29,496	equal to	29,496	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	128,966	equal to	128,966	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	29,212	equal to	29,212	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	78,359	equal to	78,359	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	58,231	equal to	58,231	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	91,607	equal to	91,607	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	31,571	equal to	31,571	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	1,394,402	equal to	1,302,795	91,607	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,400	< or = to	14,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	5,191	< or = to	7,837	-2,646	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to	225	-225	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	91,607	equal to	91,607	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	270,100	equal to	270,100	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	9,394	equal to	9,394	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	190,996	equal to	190,996	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	5,752	equal to	5,752	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	48	equal to	48	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	167,723	equal to	167,723	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medical	761	equal to	831	-70	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	44,237	equal to	44,237	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	2,352,551	equal to	2,352,551	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	17,760	equal to	17,760	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	184,891	equal to	184,891	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,102,507	equal to	2,102,507	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and i	237,082	equal to	237,082	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	1,302,126	equal to	1,302,126	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	-4,081,358	equal to	-4,081,358	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	485,683	equal to	485,683	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,342,484	equal to	4,342,484	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	128,966	11,128	0	140,094	0	140,094	-465	139,629
2. Food Purchase	0	130,126	0	130,126	0	130,126	-5,170	124,956
3. Housekeeping	78,359	16,903	0	95,262	0	95,262	-3,265	91,997
4. Laundry	58,231	13,731	0	71,962	0	71,962	-2,525	69,437
5. Heat and Other Utilities	0	0	91,623	91,623	0	91,623	-2,956	88,667
6. Maintenance	29,212	12,925	30,497	72,634	0	72,634	-119	72,515
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	294,768	184,813	122,120	601,701	0	601,701	-14,500	587,201
9. Medical Director	0	0	14,400	14,400	0	14,400	0	14,400
10. Nursing & Medical Records	907,024	55,732	7,837	970,593	0	970,593	-824	969,769
10a. Therapy	0	0	123,295	123,295	0	123,295	0	123,295
11. Activities	39,936	517	225	40,678	0	40,678	-2,675	38,003
12. Social Services	29,496	0	0	29,496	0	29,496	0	29,496
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	976,456	56,249	145,757	1,178,462	0	1,178,462	-3,499	#####
17. Administrative	0	0	270,100	270,100	0	270,100	-178,493	91,607
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	9,394	9,394	0	9,394	23,232	32,626
20. Fees, Subscriptions & Promotion	0	0	5,343	5,343	0	5,343	409	5,752
21. Clerical & General Office	31,571	3,587	12,042	47,200	0	47,200	51,797	98,997
22. Employee Benefits & Payroll	0	0	161,982	161,982	0	161,982	29,014	190,996
23. Inservice Training & Education	0	0	150	150	0	150	99	249
24. Travel and Seminar	0	0	0	0	0	0	48	48
25. Other Admin. Staff Trans	0	0	3,488	3,488	0	3,488	4,082	7,570
26. Insurance-Prop.Liab.Malpractice	0	0	24,068	24,068	0	24,068	575	24,643
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	31,571	3,587	486,567	521,725	0	521,725	-69,237	452,488
29. Total General Administrative	1,302,795	244,649	754,444	2,301,888	0	2,301,888	-87,236	#####
30. Depreciation	0	0	4,219	4,219	0	4,219	67,400	71,619
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	7,271	7,271
32. Interest	0	0	0	0	0	0	154,461	154,461
33. Real Estate	0	0	18,092	18,092	0	18,092	264	18,356
34. Rent - Facility & Grounds	0	0	161,829	161,829	0	161,829	-161,829	0
35. Rent - Equipment & Vehicles	0	0	5,485	5,485	0	5,485	934	6,419
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	189,625	189,625	0	189,625	68,501	258,126
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	23,162	0	23,162	0	23,162	0	23,162
40. Barber and Beauty Shop	0	0	16	16	0	16	0	16
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	167,723	167,723	0	167,723	0	167,723
43. Other (specify):*	0	37	28,931	28,968	0	28,968	-28,968	0
44. Total Special Cost Ce	0	23,199	196,670	219,869	0	219,869	-28,968	190,901
45. Grand Total	1,302,795	267,848	1,140,739	2,711,382	0	2,711,382	-47,703	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	3,112,127	3,112,127
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,179,273	1,179,273
4. Supply Inventory	10,964	10,964
5. Short-Term Investments	0	0
6. Prepaid Insurance	24,328	24,328
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	1,025	1,025
10. Total current assets	4,327,717	4,327,717
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	184,891
14. Buildings, at Historical Cost	0	1,669,127
15. Leasehold Improvements, Historical Cost	11,784	433,380
16. Equipment, at Historical Cost	45,820	237,082
17. Accumulated Depreciation (book methods)	-42,837	-1,302,126
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	385,250
24. Total Long-Term Assets	14,767	1,607,604
25. Total Assets	4,342,484	5,935,321
CURRENT LIABILITIES		
26. Accounts Payable	512,588	512,588
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	6,236	6,236
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	74,887	74,887
31. Accrued Taxes Payable	109,553	109,553
32. Accrued Real Estate Taxes	17,760	17,760
33. Accrued Interest Payable	0	10,130
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	300,555	300,555
37. Other Current Liabilities (specify):	444,203	444,203
38. Total Current Liabilities	1,465,782	1,475,912
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	2,352,551
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	6,958,060	6,958,060
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	6,958,060	9,310,611
46.Total Liabilities	8,423,842	10,786,523
47.Total Equity	#####	-4,851,202
48.Total Liabilities and Equity	4,342,484	5,935,321

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,972,319
2. Discounts and Allowances for all Levels	-74,519
Subtotal - Inpatient Care	2,897,800
4. Day Care	0
5. Other Care for Outpatients	38,012
6. Therapy	210,404
7. Oxygen	251
Subtotal - Ancillary Revenue	248,667
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	685
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	41,206
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	1,832
21. Other Medical Services	3,152
22. Laundry	0
Subtotal - Other Operating Revenue	46,875
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	2,675
28. Other Revenue (specify):	1,048
Subtotal - Other Revenue	3,723
30. Total Revenue	3,197,065
31. General Services	145,894
32. Health Care	296,787
33. General Administration	128,288
34. Ownership	46,170
35. Special Cost Centers	15,622
35. Provider Participation Fee	41,100
37. Other	0
40. Total Expenses	673,861
41. Income Before Income Taxes	2,523,204
42. Income Taxes	0
43. Net Income or Loss for the Year	2,523,204