FOR BHF USE							

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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 (Number) Brighton (City) 62012 (Zip Code)

County: Macoupin

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

HFS ID Number:

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

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 1/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) ____ (Date)
	(Type or Print Name) Mark B. Petersen
	(Title) Chief Executive Officer
Paid Preparer	(Signed) ____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	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			1,946	1,946	8
9	SNF/PED					9
10	ICF	15,412	4,192	1,243	20,847	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,412	4,192	3,189	22,793	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.26%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Independent Living

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date ______ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 1,946

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	120,430	13,572		134,002		134,002	(5,781)	128,221			1
2	Food Purchase		121,228		121,228		121,228	(12,601)	108,627			2
3	Housekeeping	65,704	14,043		79,747		79,747	(5,877)	73,870			3
4	Laundry	64,227	17,355		81,582		81,582	(6,039)	75,543			4
5	Heat and Other Utilities			70,467	70,467		70,467	(4,895)	65,572			5
6	Maintenance	28,406	12,919	23,463	64,788		64,788	(2,499)	62,289			6
7	Other (specify):* Home Off. Ben. All.							553	553			7
8	TOTAL General Services	278,767	179,117	93,930	551,814		551,814	(37,139)	514,675			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	864,229	31,675	3,428	899,332		899,332	(511)	898,821			10
10a	Therapy		32	268,200	268,232		268,232		268,232			10a
11	Activities	22,267	121	1,670	24,058		24,058	(5,023)	19,035			11
12	Social Services	26,855			26,855		26,855		26,855			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	913,351	31,828	288,898	1,234,077		1,234,077	(5,534)	1,228,543			16
	C. General Administration											
17	Administrative			100,800	100,800		100,800	(16,545)	84,255			17
18	Directors Fees											18
19	Professional Services			2,582	2,582		2,582	22,414	24,996			19
20	Dues, Fees, Subscriptions & Promotions			846	846		846	246	1,092			20
21	Clerical & General Office Expenses	37,359	5,134	108,160	150,653		150,653	46,752	197,405			21
22	Employee Benefits & Payroll Taxes			183,629	183,629		183,629		183,629			22
23	Inservice Training & Education			70	70		70	78	148			23
24	Travel and Seminar							8	8			24
25	Other Admin. Staff Transportation			4,297	4,297		4,297	5,382	9,679			25
26	Insurance-Prop.Liab.Malpractice			25,576	25,576		25,576	887	26,463			26
27	Other (specify):* Home Off. Ben. All.							11,080	11,080			27
28	TOTAL General Administration	37,359	5,134	425,960	468,453		468,453	70,302	538,755			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,229,477	216,079	808,788	2,254,344		2,254,344	27,629	2,281,973			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Robings Manor Rehab & Health Care #0026716 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			103,135	103,135		103,135	(37,637)	65,498			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			242,257	242,257		242,257	7,684	249,941			32
33	Real Estate Taxes			15,369	15,369		15,369	587	15,956			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,280	10,280		10,280	584	10,864			35
36	Other (specify):*											36
37	TOTAL Ownership			371,041	371,041		371,041	(28,782)	342,259			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,063		86,063		86,063		86,063			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			248,351	248,351		248,351		248,351			42
43	Other (specify):* Non-allowable Costs		518	29,665	30,183		30,183	(30,183)				43
44	TOTAL Special Cost Centers		86,581	278,016	364,597		364,597	(30,183)	334,414			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,229,477	302,660	1,457,845	2,989,982		2,989,982	(31,336)	2,958,646			45

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	(3,758)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,560)	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	(13,098)	30		9
10	Interest and Other Investment Income	(242)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(251)	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	(13,403)	43		18
19	Entertainment				19
20	Contributions	(11)	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	(1,771)	43		24
25	Fund Raising, Advertising and Promotional	(1,330)	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	(82,136)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,560)		$	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)	91,224	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 91,224		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (31,336)		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

STATE OF ILLINOIS

Robings Manor Rehab & Health Care

ID# 0026716

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (668)	43	1
2	X-Rays-Part A	(3,110)	43	2
3	IDES Penalty Interest	(2,519)	43	3
4	Resident Flowers	(560)	43	4
5	Disallowed Chamber of Commerce Dues	(73)	20	5
6	Independent Living Dietary Cost Offset	(9,930)	1	6
7	Independent Living Food Cost Offset	(8,983)	2	7
8	Independent Living Housekeeping Cost Offset	(5,909)	3	8
9	Independent Living Laundry Cost Offset	(6,045)	4	9
10	Independent Living Utilties Cost Offset	(5,222)	5	10
11	Indpendent Living Maintenance Cost Offset	(4,801)	6	11
12	Offset of Office Supplies Income	(216)	21	12
13	Indpendent Living Depreciation Offset	(28,526)	30	13
14	Offset of Transportation Revenue	(5,023)	11	14
15	Offset of Nursing Supplies Revenue	(551)	10	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**	(82,136)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	(9,930)	4,149	0	0	0	0	0	0	0	0	0	(5,781)	1
2	Food Purchase	(12,741)	140	0	0	0	0	0	0	0	0	0	(12,601)	2
3	Housekeeping	(5,909)	32	0	0	0	0	0	0	0	0	0	(5,877)	3
4	Laundry	(6,045)	6	0	0	0	0	0	0	0	0	0	(6,039)	4
5	Heat and Other Utilities	(5,222)	327	0	0	0	0	0	0	0	0	0	(4,895)	5
6	Maintenance	(4,801)	2,302	0	0	0	0	0	0	0	0	0	(2,499)	6
7	Other (specify):*	0	553	0	0	0	0	0	0	0	0	0	553	7
8	**TOTAL General Services**	(44,648)	7,509	0	0	0	0	0	0	0	0	0	(37,139)	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	(551)	40	0	0	0	0	0	0	0	0	0	(511)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(5,023)	0	0	0	0	0	0	0	0	0	0	(5,023)	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**	(5,574)	40	0	0	0	0	0	0	0	0	0	(5,534)	16
	C. General Administration													
17	Administrative	0	(16,545)	0	0	0	0	0	0	0	0	0	(16,545)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	22,414	0	0	0	0	0	0	0	0	0	22,414	19
20	Fees, Subscriptions & Promotions	(73)	0	319	0	0	0	0	0	0	0	0	246	20
21	Clerical & General Office Expenses	(216)	0	46,968	0	0	0	0	0	0	0	0	46,752	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	78	0	0	0	0	0	0	0	0	78	23
24	Travel and Seminar	0	0	8	0	0	0	0	0	0	0	0	8	24
25	Other Admin. Staff Transportation	0	0	5,382	0	0	0	0	0	0	0	0	5,382	25
26	Insurance-Prop.Liab.Malpractice	0	0	887	0	0	0	0	0	0	0	0	887	26
27	Other (specify):*	0	0	11,080	0	0	0	0	0	0	0	0	11,080	27
28	**TOTAL General Administration**	(289)	5,869	64,722	0	0	0	0	0	0	0	0	70,302	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(50,511)	13,418	64,722	0	0	0	0	0	0	0	0	27,629	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(41,624)	0	3,987	0	0	0	0	0	0	0	0	(37,637)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(242)	0	7,926	0	0	0	0	0	0	0	0	7,684	32
33	Real Estate Taxes	0	0	587	0	0	0	0	0	0	0	0	587	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	584	0	0	0	0	0	0	0	0	584	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(41,866)	0	13,084	0	0	0	0	0	0	0	0	(28,782)	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):*	(30,183)	0	0	0	0	0	0	0	0	0	0	(30,183)	43
44	TOTAL Special Cost Centers	(30,183)	0	0	0	0	0	0	0	0	0	0	(30,183)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(122,560)	13,418	77,806	0	0	0	0	0	0	0	0	(31,336)	45

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 4,149	$ 4,149	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	140	140	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	32	32	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	6	6	4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	327	327	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,302	2,302	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	553	553	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	40	40	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	100,800	Petersen Health Care, Inc.	100.00%	84,255	(16,545)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	22,414	22,414	12
13	V								13
14	Total			$ 100,800			$ 114,218	$ * 13,418	14

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	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%	$ 319	$ 319	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	46,968	46,968	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	78	78	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	8	8	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	5,382	5,382	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	887	887	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	11,080	11,080	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	3,987	3,987	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	7,926	7,926	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	587	587	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%	584	584	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			$			$ 77,806	$ * 77,806	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: 1/1/2012 Ending: 12/31/2012

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 Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care \	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care \	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	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care)	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	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: 1/1/2012 Ending: 12/31/2012

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				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								28
29								29
30								30

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
	Name	Title	Function	Ownership Interest		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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,569,393	74	$ 285,707	$ 284,214	22,793	$ 4,149	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	22,793	140	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	22,793	32	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	22,793	6	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	22,793	327	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	22,793	2,302	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	22,793	553	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	22,793	40	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	22,793	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	22,793	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	22,793	84,255	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	22,793	22,414	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	22,793	319	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	22,793	46,968	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	22,793	78	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	22,793	8	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	22,793	5,382	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	22,793	887	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	22,793	11,080	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	22,793	3,987	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	22,793	7,926	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	22,793	587	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	22,793	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	22,793	584	24
25	TOTALS					$ 11,774,077	$ 7,528,087		$ 192,024	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	$ 2,901,178	12/31/13	Variable	$ 242,257	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 3,225,000	$ 2,901,178			$ 242,257	9
	B. Non-Facility Related*											
10												10
11								Interest Income Offset			(242)	11
12								Home Office Allocation-PHC			7,926	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,684	14
15	TOTALS (line 9+line14)						$ 3,225,000	$ 2,901,178			$ 249,941	15

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

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

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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.

Item		Amount	Line
1. Real Estate Tax accrual used on 2011 report.		$ 15,540	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.)	2011	$ 15,225	2
3. Under or (over) accrual (line 2 minus line 1).		$ (315)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 15,684	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**	587 $	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 15,956	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Year	Amount	Line
	2007	13,850	8
	2008	14,028	9
	2009	14,807	10
	2010	15,035	11
	2011	15,225	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.**

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Robings Manor Rehab & Health Care COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0026716

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2011 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 2011.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	21-001-047-00	Lot 12, Albro Palmers etal sub div	$ 6,412.94	$ 6,412.94
2.	21-001-048-00	N Pt Lot 13 A Palmers etal sub div	$ 8,046.40	$ 8,046.40
3.	21-001-049-00	40 Ctr Lot 13 A Palmers etal sub div	$ 765.38	$ 765.38
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 15,224.72	$ 15,224.72

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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,072 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

N/A

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	246,281	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	230	714	14,285	16
17	Various			1995	18,999		20	950	950	16,305	17
18	Tile flooring			1996	991		20	50	50	849	18
19	Curtains			1996	3,187		20	159	159	2,638	19
20	Mini blinds			1996	358		20	18	18	299	20
21	Concrete parking lot			1996	1,250		20	63	63	1,033	21
22	Paving and lining parking lot			1996	8,325		20	416	416	6,692	22
23	Electrical box			1997	3,777		20	189	189	3,024	23
24	Medicare survey			1997	1,543		20	77	77	1,194	24
25	Windows			1997	1,640		20	82	82	1,271	25
26	Screen patio			1997	8,369		20	418	418	6,410	26
27	Seal coat parking lot			1997	675		20	34	34	519	27
28	Landscaping			1998	4,553		15	304	304	4,302	28
29	Remodeling			1998	1,822		20	91	91	1,320	29
30	Siding & windows			1998	39,885		20	1,994	1,994	28,914	30
31	Outdoor sign			1999	1,036		20	52	52	728	31
32	Sprinkler heads			1999	2,187		20	109	109	1,527	32
33	Handicapped bathrooms			1999	23,785		20	1,189	1,189	15,351	33
34	Nurse call system			1999	3,648		20	182	182	2,549	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	$ 15,218	37
38	Fencing	1999	2,777		20	139	139	1,946	38
39	Windows	1999	1,250		20	63	63	881	39
40	Garage & patio	1999	15,560		20	778	778	10,892	40
41	Windows	2000	1,233		20	62	62	774	41
42	Key system	2000	1,080		20	54	54	675	42
43	Resurface parking lot	2000	1,950		20	98	98	1,224	43
44	Kitchen remodeling	2001	2,152		20	108	108	1,241	44
45	Air compressor	2001	5,900		20	295	295	3,393	45
46	Carpet	2001	1,221		20	61	61	702	46
47	New roof - shed	2001	1,320		20	66	66	759	47
48	Remodel skilled units	2001	5,897		20	295	295	3,392	48
49	Building upgrades	2002	4,937		20	247	247	2,593	49
50	Nurses station cabinets	2002	2,369		20	118	118	1,240	50
51	Gutters and drains	2003	3,400		20	170	170	1,615	51
52	Hot water heater	2003	1,932		20	97	97	920	52
53	Boiler/Hot Water	2004	1,525		20	76	76	647	53
54	ADT Smoke detector	2004	6,176		20	309	309	2,626	54
55	Fire Suppression System	2004	1,920		20	96	96	816	55
56	Landscaping Improvements	2005	11,483		20	574	574	4,305	56
57	Architect Fees	2005	7,996		20	400	400	3,000	57
58	Fire System	2006	10,250		25	410	410	2,563	58
59	Generator	2006	5,260		15	351	351	2,281	59
60	Carpeting	2007	590		10	59	59	325	60
61	HVAC in Laundry Building	2007	6,900		15	460	460	2,530	61
62	Tile Replacement	2008	11,066		15	738	738	3,321	62
63	Sprinkler Installation on Outside Porch	2009	2,600		15	174	174	609	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,051,138	$		$ 49,175	$ 49,659	$ 876,963	70

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	$		$ 49,175	$ 49,175	$ 876,963	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	Land Improvements Booked			1,499			(1,499)		26
27	Building Improvement Booked			57,870			(57,870)		27
28									28
29	2011-Home Office Allocation-Building Improvements		10,660			256	256		29
30	2011-Home Office Allocation-Land Improvements		995			64	64		30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,062,793	$ 59,369		$ 49,495	$ (9,874)	$ 876,963	34

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	$ 45,201	$ 7,423	$ 4,520	$ (2,903)	10 yrs.	$ 24,562	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	289,582					289,582	73
74	Home Office Allocation			3,667	3,667			74
75	TOTALS	$ 334,783	$ 7,423	$ 8,187	$ 764		$ 314,144	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	7,817	7,816	(1)	5 yrs.	11,724	78
79										79
80	TOTALS			$ 90,664	$ 7,817	$ 7,816	$ (1)		$ 63,304	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,673,131	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 103,135	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,498	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,111)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,254,411	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	$ 177,550	86
87	Independent Living-2007	15,749	1,726	9,493	87
88					88
89					89
90					90
91	TOTALS	$ 685,749	$ 28,526	$ 187,043	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.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

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

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .
9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 10,864 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			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

Robings Manor Rehab & Health Care
0026716
Period Beginning **1/1/2012**
Period End **12/31/2012**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 4,311
Dishwasher	740
Laundry Equipment	-
Copier	5,229
Home Office Allocation	584
	10,864

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	7,184	$ 107,755	$	7,184	$ 107,755	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,642	54,633		3,642	54,633	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,029	105,429	32	7,029	105,461	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				86,063		86,063	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)				383			383	13
14	TOTAL			$	17,855	$ 268,200	$ 86,095	17,855	$ 354,295	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (last day of reporting year)

This report must be completed even if f 3,722,546

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,711,752	$ 4,711,752	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 65,000)	684,162	684,162	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,428	25,428	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)**	$ 6,495,874	$ 6,495,874	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	219,058	184,891	13
14	Buildings, at Historical Cost	372,302	1,670,220	14
15	Leasehold Improvements, at Historical Cost	2,332,130	392,573	15
16	Equipment, at Historical Cost	446,746	425,447	16
17	Accumulated Depreciation (book methods)	(1,545,557)	(1,254,411)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,824,679	$ 1,418,720	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,320,553	$ 7,914,594	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 652,938	$ 652,938	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	73,318	73,318	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,587	5,587	31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,684	15,684	32
33	Accrued Interest Payable	8,109	8,109	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	38,705	38,705	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 794,341	$ 794,341	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,901,178	2,901,178	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	A/P-Other	490,293	490,293	43
44	Security Deposit	6,236	6,236	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,397,707	$ 3,397,707	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,192,048	$ 4,192,048	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,128,505	$ 3,722,546	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,320,553	$ 7,914,594	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,253,980	1
2	Restatements (describe):		2
3	Rounding	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,253,978	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	874,527	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)**	$ 874,527	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)**	$ 4,128,505	24 *

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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,521,481	1
2	Discounts and Allowances for all Levels	(252,801)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,268,680	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	427,746	6
7	Oxygen	904	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 428,650	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	3,758	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	141,408	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,961	20
21	Other Medical Services	6,020	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 161,147	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	242	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 242	26
	E. Other Revenue (specify):****		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	Miscellaneous Revenue	767	28
28a	Transportation Revenue	5,023	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,790	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,864,509	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	551,814	31
32	Health Care	1,234,077	32
33	General Administration	468,453	33
	B. Capital Expense		
34	Ownership	371,041	34
	C. Ancillary Expense		
35	Special Cost Centers	116,246	35
36	Provider Participation Fee	248,351	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,989,982	40
41	**Income before Income Taxes (line 30 minus line 40)****	874,527	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 874,527	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,155,963	44
45	Private Pay - Net Inpatient Revenue	745,118	45
46	Medicare - Net Inpatient Revenue	371,544	46
47	Other-(specify) Charity Therapy Allowance	(2,772)	47
48	Other-(specify) Insurance Contracual Allowance	(1,173)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,268,680	49

* 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.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 64,786	$ 31.15	1
2	Assistant Director of Nursing	2,080	2,080	45,718	21.98	2
3	Registered Nurses	9,894	10,160	230,365	22.67	3
4	Licensed Practical Nurses	5,029	5,646	111,467	19.74	4
5	CNAs & Orderlies	38,091	39,684	386,536	9.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,884	1,884	21,438	11.38	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,140	26,855	12.55	11
12	Dietician					12
13	Food Service Supervisor	2,025	2,025	29,646	14.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,082	10,533	90,784	8.62	15
16	Dishwashers					16
17	Maintenance Workers	1,843	1,912	28,406	14.86	17
18	Housekeepers	7,252	7,618	65,704	8.62	18
19	Laundry	7,278	7,549	64,227	8.51	19
20	Administrator	2,080	2,080	84,255	40.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,436	2,436	37,359	15.34	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Restorative Aide	1,739	1,896	25,357	13.37	32
33	Other(specify) Transportation	100	100	829	8.29	33
34	TOTAL (lines 1 - 33)	95,973	99,823	$ 1,313,732 *	$ 13.16	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	15,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	4,211	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		(25)	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 19,786		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

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Shaw	Administrator	0	$ 84,255
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 84,255

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 100,800
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 100,800

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 1,395
AT&T	Computer Services	635
Honkamp Krueger & Company	Accounting Fees	552
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 2,582

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,050
Unemployment Compensation Insurance	36,196
FICA Taxes	87,871
Employee Health Insurance	24,563
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	1,898
Employee Retirement	857
Life Insurance	194
TOTAL (agree to Schedule V, line 22, col.8)	$ 183,629

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

Description	Line #	Amount
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$
Advertising: Employee Recruitment		10
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks	52	520
Miscellaneous Licenses & Permits		243
Miscellaneous Dues & Subscriptions		73
Home Office Allocation		319
Less: Public Relations Expense		(73)
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 1,092

G. Schedule of Travel and Seminar**

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

**See instructions.

Robings Manor Rehab & Health Care
0026716
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,582
Home Office Allocation		
Sorling Northrup	Legal	71
Ginoli & Company	Accountants	753
Miscellaneous Vendors	Computer Services	63
Nebo Systems	Computer Services	2
Advanced Answers on Demand	Computer Services	3,463
Access 2 Go	Computer Services	146
Stratus Networks	Computer Services	143
Kemper Technology	Computer Services	236
CCH	Computer Services	12
MediFax	Computer Services	28
Vision Share/Ability Network	Computer Services	264
Barracauda	Computer Services	9
CIAN	Computer Services	72
Comcast	Computer Services	22
Postini	Computer Services	224
Optimizer Systems	Other Prof Fees	35
Marotta Gund Budd & Derza	Other Prof Fees	16,038
David Budde	Other Prof Fees	13
Courtney Bourban	Other Prof Fees	197
AllScripts	Other Prof Fees	605
Heritage Enterprises	Other Prof Fees	14
Miscellaneous Vendors	Other Prof Fees	4
Total (agree to Schedule V, line 19, column 8)		24,996

Facility Name & ID Number Robings Manor Rehab & Health Care # 0026716 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,631** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **248,351**
This amount is to be recorded on line 42 of Schedule V.

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

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,758**

(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. $ **5,023**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Company**

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

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

Robings Manor Rehab & Health Care
0026716
Period Beginning **1/1/2012**
Period End **12/31/2012**

Independent Living Offset

Schedule 23A

Census Days Summary:	**Days**	**%**
Independent Living	1,824	7.41%
Nursing Home	22,793	92.59%
	24,617	100.00%

Expense Offset:	**Total Amount**	**Ind. Liv %**	**Ind. Liv Offset**	**Basis For Allocation**	**Line**
Dietary	134,002	7.41%	9,930	Census	1
Food	121,228	7.41%	8,983	Census	2
Housekeeping	79,747	7.41%	5,909	Census	3
Laundry	81,582	7.41%	6,045	Census	4
Utilities	70,467	7.41%	5,222	Census	5
Maintenance	64,788	7.41%	4,801	Census	6
Depreciation (Building)	28,526	100.00%	28,526	Beds	30
Total	580,340		69,416		

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.