

		FOR BHF USE			

LL2

**Supportive Living Facility**

**2012  
STATE OF ILLINOIS  
DEPARTMENT OF HEALTHCARE & FAMILY SERVICES  
COST REPORT FOR  
SUPPORTIVE LIVING FACILITIES  
(FISCAL YEAR 2012)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN SECTION 146.265 OF THE 89 IL ADMIN CODE. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS.

<p><b>I. Facility ID Number:</b> <u>1000017</u></p> <p><b>Facility Name:</b> <u>ROBBINS SUPPORTIVE LIVING</u></p> <p><b>Address:</b> <u>13820 UTICA AVE</u> <u>ROBBINS</u> <u>60472</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>COOK</u></p> <p><b>Telephone Number:</b> <u>( 708 ) 389-7140</u> Fax # <u>(708) 389-7141</u></p> <p><b>Federal Employer ID Number:</b> _____</p> <p><b>Date Current Owners were Certified:</b> <u>9/30/2002</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td>_____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td>_____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>ANDREW B. CUTLER</u> <b>Telephone Number:</b> <u>(847) 374-0400</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input checked="" type="checkbox"/> Limited Liability Co.	_____		<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%"> <tr> <td rowspan="2" style="width:20%; vertical-align: top;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4" style="vertical-align: top;"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td align="right">(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>ANDREW B. CUTLER</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>FGMK, LLC</u> <u>2801 LAKESIDE DRIVE BANNOCKBURN, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 374-0400</u> Fax <u>(847) 34-0420</u></td> </tr> </table> <p align="right">MAIL TO: BUREAU OF HEALTH FINANCE  IL DEPT OF HEALTHCARE AND FAMILY SERVICES  201 S. Grand Avenue East  Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) _____		(Title) _____	<b>Paid Preparer</b>	(Signed) _____	(Date) _____	(Print Name and Title) <u>ANDREW B. CUTLER</u>	(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 LAKESIDE DRIVE BANNOCKBURN, IL 60015</u>		(Telephone) <u>(847) 374-0400</u> Fax <u>(847) 34-0420</u>
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Facility Name ROBBINS SUPPORTIVE LIVING

Report Period Beginning: 1/1/2012 Ending: 12/31/2012

**III. STATISTICAL DATA**

**A. Certified units; enter number of units and unit days**

Date of change in certified units N/A

	1	2	3	4	
	Units at Beginning of Report Period	Type of Apartment	Units at End of Report Period	Unit Days During Report Period	
1	103	Single Unit Apartment	103	37,595	1
2	25	Double Unit Apartment	25	9,125	2
3		Other			3
4	128	TOTALS	128	46,720	4

**B. Census-For the entire report period.**

	1 Type of Unit	2 3 4 5 Resident Days by Unit and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
5	Single Unit	30,102	957		31,059	5
6	Double Unit					6
7	Other					7
8	TOTALS	30,102	957		31,059	8

**C. Percent Occupancy.** (Column 5, line 8 divided by total certified bed days on line 4, column 4.) 66.48%

**D. Indicate the number of paid bed-hold days the SLF had during this year** 379 Also, indicate the number of unpaid bed-hold days the SLF had during this year. 51 (Do not include bed-hold days in Section B.)

**E. Does page 3 include expenses for services or investments not directly related to SLF services?**

YES  NO

**F. Does the BALANCE SHEET reflect any non-SLF assets?**

YES  NO

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

N/A

**H. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

**I. Is your fiscal year identical to your tax year?**  YES  NO

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

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

**J. Does the facility have any Illinois Housing Development Authority Loans outstanding?** NO If yes, did the facility make all of the required payments of interest and principle? N/A  
If no, explain. \_\_\_\_\_

**K. Does the facility have any loans from the Federal Home Loan Bank outstanding?** NO If yes, did the facility make all of the required payments of interest and principle? N/A  
If no, explain. \_\_\_\_\_

**L. Does the facility have any loans from the IL Dept of Commerce and Economic Opportunity outstanding?** NO If yes, did the facility make all of the required payments of interest and principle? N/A  
If no, explain. \_\_\_\_\_

Facility Name: ROBBINS SUPPORTIVE LIVING

Report Period Beginning:

1/1/2012

Ending: 12/31/2012

## IV. COST CENTER EXPENSES (please round to the nearest dollar)

Operating Expenses		Costs Per General Ledger				Reclassifications and Adjustments	Adjusted Total	
		Salary/Wage 1	Supplies 2	Other 3	Total 4			
<b>A. General Services</b>								
1	Dietary and Food Purchase	179,123	173,139	27,673	379,935	(13)	379,922	1
2	Housekeeping, Laundry and Maintenance	173,498	30,577	66,089	270,164	(28,824)	241,340	2
3	Heat and Other Utilities			93,869	93,869	(362)	93,507	3
4	Other (specify):							4
5	<b>TOTAL General Services</b>	<b>352,621</b>	<b>203,716</b>	<b>187,631</b>	<b>743,968</b>	<b>(29,199)</b>	<b>714,769</b>	<b>5</b>
<b>B. Health Care and Programs</b>								
6	Health Care/ Personal Care	480,043	8,747	10,118	498,908	4,237	503,145	6
7	Activities and Social Services	47,435	5,718	152	53,305	(152)	53,153	7
8	Other (specify):							8
9	<b>TOTAL Health Care and Programs</b>	<b>527,478</b>	<b>14,465</b>	<b>10,270</b>	<b>552,213</b>	<b>4,085</b>	<b>556,298</b>	<b>9</b>
<b>C. General Administration</b>								
10	Administrative and Clerical	185,686	4,021	310,541	500,248	(47,586)	452,662	10
11	Marketing Materials, Promotions and Advertising	29,503			29,503		29,503	11
12	Employee Benefits and Payroll Taxes			279,857	279,857	12,721	292,578	12
13	Insurance-Property, Liability and Malpractice			86,565	86,565	(863)	85,702	13
14	Other (specify):							14
15	<b>TOTAL General Administration</b>	<b>215,189</b>	<b>4,021</b>	<b>676,963</b>	<b>896,173</b>	<b>(35,728)</b>	<b>860,445</b>	<b>15</b>
16	<b>TOTAL Operating Expense (Sum of lines 5, 9 and 15)</b>	<b>1,095,288</b>	<b>222,202</b>	<b>874,864</b>	<b>2,192,354</b>	<b>(60,843)</b>	<b>2,131,511</b>	<b>16</b>
<b>Capital Expenses</b>								
<b>D. Ownership</b>								
17	Depreciation			19,902	19,902	(11,798)	8,104	17
18	Interest			94,852	94,852	151,750	246,602	18
19	Real Estate Taxes					183,468	183,468	19
20	Rent -- Facility and Grounds			622,616	622,616	(620,216)	2,400	20
21	Rent -- Equipment			6,081	6,081	783	6,864	21
22	Other (specify):					733	733	22
23	<b>TOTAL Ownership</b>			<b>743,451</b>	<b>743,451</b>	<b>(295,280)</b>	<b>448,171</b>	<b>23</b>
24	<b>GRAND TOTAL (Sum of lines 16 and 23)</b>	<b>1,095,288</b>	<b>222,202</b>	<b>1,618,315</b>	<b>2,935,805</b>	<b>(356,122)</b>	<b>2,579,683</b>	<b>24</b>

**ROBBINS SUPPORTIVE LIVING**

Report Period Beginning: 1/1/2012  
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Non-Straight Line Depreciation	\$ (13,348)	17	1
2	Misc Income	(1,217)	10	2
3	Interest Income	(57)	18	3
4	Cable TV	(22,565)	10	4
5	Bank Charges	(9,476)	10	5
6	Bad Debts	(31,300)	10	6
7	Non-Allowable Interest Expense	(94,114)	18	7
8	Non-Allowable Legal	(6,900)	10	8
9	Non-Allowable Dues (Political)	(645)	10	9
10	Non-Allowable Contracted Services (Stujac)	(24,998)	02	10
11	Non-Allowable Insurance (Stujac)	(1,155)	13	11
12				12
13	BUILDING COMPANY:			13
14	Rent Income	(622,616)	20	14
15	Amortization	733	22	15
16	Interest Expense	246,659	18	16
17	Legal & Accounting Fees	8,256	10	17
18	Other Professional Fees	3,025	10	18
19	Real Estate Taxes	183,468	19	19
20				20
21	MANAGEMENT OFFICE ALLOCATION:			21
22	Management Office Allocation	(23,486)	10	22
23	Allowable Office Expense	15,527	10	23
24				24
25	APEX HEALTHCARE ALLOCATION:			25
26	Health Care Salaries	3,324	06	26
27	Employee Benefits-Healthcare	2,653	12	27
28	Administrative Salaries	110,949	10	28

29	Emp. Ben. - Gen. Admin.	24,650	12	29
30	General and Administrative Expenses	5,164	10	30
31	Seminars	1,472	10	31
32	Auto & Travel	16,608	10	32
33	Insurance	292	13	33
34	Deprciation	1,550	17	34
35	Rent	2,400	20	35
36	Equipment Rental	783	21	36
37	Facility Wages reimbursed	(1,173)	02	37
38	Management Office Allocation	(105,443)	10	38
39				39
40	PPD Dietary	(13)	01	40
41	PPD R&M	(2,653)	02	41
42	PPD Utilities	(362)	03	42
43	PPD Resident Supplies	311	06	43
44	PPD Uniforms	602	06	44
45	PPD Activities	(152)	07	45
46	PPD Legal	(7,555)	10	46
47	PPD Benefits	(14,582)	12	47
48	PPD Interest Income	(738)	18	48
49				49
50				50
51	<b>Total</b>	(356,122)		51

Facility Name: **ROBBINS SUPPORTIVE LIVING**

Report Period Beginning **1/1/2012** Ending: **12/31/2012**

**V. STAFFING AND SALARY COSTS (Please report each line separately.)**

	Personnel	Number of FTE	Average Hourly Wage	
1	Registered Nurses	1.14	\$ 27.69	1
2	Licensed Practical Nurses	4.28	21.43	2
3	Certified Nurse Assistants	11.00	9.78	3
4	Activity Director & Assistants	1.93	11.80	4
5	Social Service Workers			5
6	Head Cook			6
7	Cook Helpers/Assistants	6.56	13.12	7
8	Dishwashers			8
9	Maintenance Workers	1.00	15.66	9
10	Housekeepers	6.37	10.63	10
11	Laundry			11
12	Managers			12
13	Other Administrative	0.96	31.75	13
14	Clerical	5.02	11.73	14
15	Marketing	0.80	17.82	15
16	Other			16
17	<b>Total (lines 1 thru 16)</b>	<b>39.06</b>	<b>\$ 13.48</b>	<b>17</b>

**VI. (A) STATEMENT OF COMPENSATION AND OTHER PAYMENTS TO OWNERS, RELATIVES AND MEMBERS OF THE BOARD OF DIRECTORS.**

	NAME and FUNCTION	Ownership Interest	Average Hours Per Work Week Devoted to this Business	Amount of Compensation for this Reporting Period	
1	Aaron Mann, Administrative	Relative	0.3	\$ 12,292	1
2					2
3					3
4					4
5					5
				<b>Total</b>	<b>\$ 12292 6</b>

**VI. (B) Management fees paid to unrelated parties**

	Amount of Fee	
1	\$	1
2		2
<b>Total</b>		<b>\$ 3</b>

**VII. RELATED ORGANIZATIONS**

A. Enter below the names of all related organizations. Attach an additional schedule if necessary.

**RELATED SLF's & HEALTH CARE BUSINESSES**

Name	1	City	2
See Attached			

**OTHER RELATED BUSINESS ENTITIES**

Name	3	City	4	Type of Business	5
Robbins Property, LLC				Building Co.	
See Attached					

B. Does your facility receive services from a parent organization or home office; the costs for which were not included on page 3? YES  NO

Name of related entity: N/A If yes, what is the value of those services? \$ N/A

(Please attach a separate schedule itemizing those services.)

C. Does page 3 include any costs derived from transactions (including rent) with related parties? YES  NO

If so, please attach a separate schedule detailing the nature of those services, their costs as they appear on your books and the underlying cost to the related party (i.e., not including markup).

Facility Name: ROBBINS SUPPORTIVE LIVING

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VIII. OWNERSHIP COSTS

A. Purchase price of land \_\_\_\_\_ Year land was acquired \_\_\_\_\_

B. Building Depreciation -- Including Fixed Equipment. Round all numbers to the nearest dollar.

\*Total units on this schedule must agree with page 2.

	1 Units*	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	
1	128		2002	2002	\$ 6,775,910	\$ 246,397	35	\$ 193,597	\$ (52,800)	\$ 2,129,572	1
2											2
3											3
4											4
5											5
<b>Improvement Type</b>											
6	Building Improvements		2002	2002	800	30	20	40	10	440	6
7	Building Improvements		2003	2003	12,175	438	20	609	171	6,090	7
8	Building Improvements		2004	2004	53,888	1,567	20	2,697	1,130	24,245	8
9	Building Improvements		2005	2005	20,587	181	20	1,029	848	13,170	9
10	Building Improvements		2006	2006	127,281	1,652	20	6,366	4,714	60,180	10
11	Building Improvements		2007	2007	53,499		20	3,233	3,233	22,651	11
12	Building Improvements		2008	2008	320,712		20	16,033	16,033	102,140	12
13	Building Improvements		2009	2009	28,499		20	1,425	1,425	5,348	13
14	Building Improvements		2010	2010	29,203		20	1,460	1,460	3,437	14
15											15
16	Depreciation										16
17	TOTAL (lines 1 thru 16)				\$ 7,422,554	\$ 250,265		\$ 226,489	\$ (23,776)	\$ 2,367,273	17

C. Equipment Depreciation -- Including Transportation.

	Type	1 Cost	2 Current Book Depreciation	3 Straight Line Depreciation	4 Adjustments	5 Life in Years	6 Accumulated Depreciation	
18	Movable Equipment	\$ 263,877	\$ 16,034	\$ 26,462	10,428	10	\$ 185,316	18
19	Vehicles	38,934				5	38,934	19
20	TOTAL (lines 18 and 19)	\$ 302,811	\$ 16,034	\$ 26,462	10,428		\$ 224,250	20

D. Depreciable Non-Care Assets Included in General Ledger.

	1 Description and Year Acquired	2 Cost	3 Current Book Depreciation	4 Accumulated Depreciation	
21		\$	\$	\$	21
22					22
23					23
24	TOTALS (lines 21, 22 and 23)	\$	\$	\$	24

Facility Name: **ROBBINS SUPPORTIVE LIVING**

Report Period Beginning: **1/1/2012**

Ending: **2/31/2012**

**IX. RENTAL COSTS**

**A. Building and Fixed Equipment**

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?  YES  NO

		1	2	3	4	5	6	
		Year Constructed	Number of Units	Date of Lease	Rental Amount	Total Yrs. of Lease	Total Years Renewal Option*	
3	Original Building			/ /	\$			3
4	Additions			/ /				4
5	Alloc. Management Co.			/ /	6,445			5
6				/ /				6
7	<b>TOTAL</b>				\$ 6,445			7

8. Is movable equipment rental included in building rental?

YES  NO

9. Rental amount for movable equipment \$ 5,817

10. If the facility rents any vehicles which are used for care-related purposes, please attach a schedule detailing the model year and make, the rental expense for this period and the use of the vehicle.

**X. INTEREST EXPENSE**

	1	2		3	4	6		7	8	9	
		Related**				Amount of Note					
	Name of Lender	YES	NO	Purpose of Loan	Date of Note	Original	Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Int. Expense	
<b>A. Directly Facility Related</b>											
<b>Long-Term</b>											
1	Venture Fund	X		Mortgage	/ /	\$	\$ 5,328,432	/ /		\$ 246,659	1
2					/ /			/ /			2
3					/ /			/ /			3
<b>Working Capital</b>											
4	Venture Fund, LLC	X		Note Payable	/ /		3,341,895	/ /		94,852	4
5	S Lefkovitz	X		Developer	/ /		784,000	/ /			5
6	FEI Architects		X		/ /		106,975	/ /			6
7	<b>TOTAL Facility Related</b>					\$	\$ 9,561,302			\$ 341,511	7
<b>B. Non-Facility Related</b>											
8	Interest Income				/ /			/ /		-57	8
9	Non-Allowable Interest				/ /			/ /		-94,852	9
10	<b>TOTALS (lines 7, 8 and 9)</b>					\$	\$ 9,561,302			\$ 246,602	10

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

\*\* If there is any overlap in ownership between the facility and the lender, this must be indicated in column 2.

Facility Name: **ROBBINS SUPPORTIVE LIVING**

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

**XI. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2012

(last day of reporting year)

		1	2	
		Operating	After	
			Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 335,241	\$ 559,730	1
2	Cash-Patient Deposits	6,003	6,003	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	531,323	531,323	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,654	85,654	6
7	Other Prepaid Expenses	7,247	7,247	7
8	Accounts Receivable (owners or related parties)	39,989	39,989	8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,005,457	\$ 1,229,946	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		54,600	13
14	Buildings, at Historical Cost		6,775,910	14
15	Leasehold Improvements, at Historical Cost	74,287	74,287	15
16	Equipment, at Historical Cost	226,411	226,411	16
17	Accumulated Depreciation (book methods)	(237,233)	(2,752,508)	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): <u>Deposits</u>	23,376	36,425	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 86,841	\$ 4,415,125	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,092,298	\$ 5,645,071	25

		1	2	
		Operating	After	
			Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 451,191	\$ 451,191	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	262,500	262,500	29
30	Accrued Salaries Payable	34,957	34,957	30
31	Accrued Taxes Payable	11,074	11,074	31
32	Accrued Interest Payable			32
33	Deferred Compensation			33
34	Federal and State Income Taxes			34
	<b>Other Current Liabilities(specify):</b>			
35				35
36	<u>Unclaimed Property Holding</u>	314	314	36
37	<b>TOTAL Current Liabilities (sum of lines 26 thru 36)</b>	\$ 760,036	\$ 760,036	37
	<b>D. Long-Term Liabilities</b>			
38	Long-Term Notes Payable	1,894,243	9,298,802	38
39	Mortgage Payable			39
40	Bonds Payable			40
41	Deferred Compensation			41
	<b>Other Long-Term Liabilities(specify):</b>			
42				42
43				43
44	<b>TOTAL Long-Term Liabilities (sum of lines 38 thru 43)</b>	\$ 1,894,243	\$ 9,298,802	44
45	<b>TOTAL LIABILITIES (sum of lines 37 and 44)</b>	\$ 2,654,279	\$ 10,058,838	45
46	<b>TOTAL EQUITY</b>	\$ (1,561,981)	\$ (4,413,767)	46
47	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 45 and 46)</b>	\$ 1,092,298	\$ 5,645,071	47

\*(See instructions.)

Facility Name: ROBBINS SUPPORTIVE LIVING

Report Period Beginning: 1/1/2012

Ending:

12/31/2012

## XII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this Schedule to Schedule IV.)

		1	
Revenue		Amount	
<b>A. SLF Resident Care</b>			
1	Gross SLF Resident Revenue	\$ 3,047,538	1
2	Discounts and Allowances		2
3	<b>SUBTOTAL Resident Care</b> (line 1 minus line 2)	\$ 3,047,538	3
<b>B. Other Operating Revenue</b>			
4	Special Services		4
5	Other Health Care Services		5
6	Special Grants		6
7	Gift and Coffee Shop		7
8	Barber and Beauty Care		8
9	Non-Resident Meals		9
10	Laundry		10
11	<b>SUBTOTAL OTHER OPERATING REVENUE</b> (sum of lines 4 thru 10)	\$	11
<b>C. Non-Operating Revenue</b>			
12	Contributions		12
13	Interest and Other Investment Income	57	13
14	<b>SUBTOTAL Non-Operating Revenue</b> (sum of lines 12 and 13)	\$ 57	14
<b>D. Other Revenue (specify):</b>			
15	Misc. Income	1,217	15
16			16
17	<b>SUBTOTAL Other Revenue</b> (sum of lines 15 and 16)	\$ 1,217	17
18	<b>TOTAL REVENUE</b> (sum of lines 3, 11, 14 and 17)	\$ 3,048,812	18

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
19	General Services	743,968	19
20	Health Care/ Personal Care	552,213	20
21	General Administration	896,173	21
<b>B. Capital Expense</b>			
22	Ownership	743,451	22
<b>C. Other Expenses</b>			
23	Special Cost Centers		23
24	Non-Operating Expenses		24
25	Other (specify):		25
26			26
27			27
28	<b>TOTAL EXPENSES</b> (sum of lines 19 thru 27)	\$ 2,935,805	28
29	<b>Income Before Income Taxes</b> (line 18 minus line 28)	\$ 113,007	29
30	<b>Income Taxes</b>	\$	30
31	<b>NET INCOME OR LOSS FOR THE YEAR</b> (line 29 minus line 30)	\$ 113,007	31

Robbins Supportive Living, LLC

1/1/12-12/31/12

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Copier	5419
Postage Meter	398
Allocated Management Co.	<u>6445</u>
Total Equipment Rental	<u>12262</u>







