

Facility Name & ID Number Robings Manor RHC

0053504 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

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 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2,584	2,666	1,366	6,616	8
9	SNF/PED					9
10	ICF	15,695			15,695	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,279	2,666	1,366	22,311	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.50%

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

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

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

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

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

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

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 25 and days of care provided 1,326

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	125,978	11,438		137,416		137,416	(1,838)	135,578		1
2	Food Purchase		130,652		130,652		130,652	(7,395)	123,257		2
3	Housekeeping	84,010	22,291		106,301		106,301	(4,590)	101,711		3
4	Laundry	49,911	8,012		57,923		57,923	(2,518)	55,405		4
5	Heat and Other Utilities			93,946	93,946		93,946	(3,846)	90,100		5
6	Maintenance	31,791	10,462	22,558	64,811		64,811	(1,178)	63,633		6
7	Other (specify):* Home Office Ben. Allocation										7
8	TOTAL General Services	291,690	182,855	116,504	591,049		591,049	(21,365)	569,684		8
	B. Health Care and Programs										
9	Medical Director			14,400	14,400		14,400		14,400		9
10	Nursing and Medical Records	925,222	62,162	5,145	992,529		992,529	(326)	992,203		10
10a	Therapy			151,636	151,636		151,636		151,636		10a
11	Activities	25,551	180	248	25,979		25,979	(2,644)	23,335		11
12	Social Services	28,637			28,637		28,637		28,637		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Office Ben. Allocation										15
16	TOTAL Health Care and Programs	979,410	62,342	171,429	1,213,181		1,213,181	(2,970)	1,210,211		16
	C. General Administration										
17	Administrative			255,700	255,700		255,700	(166,260)	89,440		17
18	Directors Fees										18
19	Professional Services			9,791	9,791		9,791	38,146	47,937		19
20	Dues, Fees, Subscriptions & Promotions			7,014	7,014		7,014	502	7,516		20
21	Clerical & General Office Expenses	36,727	3,181	9,985	49,893		49,893	46,293	96,186		21
22	Employee Benefits & Payroll Taxes			178,319	178,319		178,319	30,918	209,237		22
23	Inservice Training & Education							319	319		23
24	Travel and Seminar							72	72		24
25	Other Admin. Staff Transportation			1,908	1,908		1,908	3,254	5,162		25
26	Insurance-Prop.Liab.Malpractice			24,234	24,234		24,234	500	24,734		26
27	Other (specify):* Home Office Ben. Allocation										27
28	TOTAL General Administration	36,727	3,181	486,951	526,859		526,859	(46,256)	480,603		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,307,827	248,378	774,884	2,331,089		2,331,089	(70,591)	2,260,498		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 RHC

#0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			102,185	102,185		102,185	(28,733)	73,452			30
31	Amortization of Pre-Op. & Org.							7,160	7,160			31
32	Interest			106,820	106,820		106,820	21,170	127,990			32
33	Real Estate Taxes			16,807	16,807		16,807	542	17,349			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,749	13,749		13,749	628	14,377			35
36	Other (specify):* Home Office Ben. Allocation											36
37	TOTAL Ownership			239,561	239,561		239,561	767	240,328			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		47,856		47,856		47,856		47,856			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			168,231	168,231		168,231		168,231			42
43	Other (specify):* Home Office Ben. Allocati		56	174,187	174,243		174,243	(174,243)				43
44	TOTAL Special Cost Centers		47,912	342,418	390,330		390,330	(174,243)	216,087			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,307,827	296,290	1,356,863	2,960,980		2,960,980	(244,067)	2,716,913			45

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

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0053504

Report Period Beginning: 1/1/2015

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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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,722)	2		4
5	Telephone, TV & Radio in Resident Rooms	(7,122)	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	(8,444)	30		9
10	Interest and Other Investment Income	(7)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(144)	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	(161,176)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,577)	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	(60,657)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (241,849)		\$	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	2	
		Amount	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)	(2,218)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,218)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (244,067)		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	2	3	4
		Yes	No	Amount	Reference
38	Medically Necessary Transport.		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44					44
45	Other-Attach Schedule		X		45
46	Other-Attach Schedule		X		46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Robings Manor RHC

ID# 0053504

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Labs-Part A	\$ (1,451)	43	1
2	X-Rays-Part A	(1,762)	43	2
3	Independent Living Depreciation Offset	(28,526)	30	3
4	Disallowed Chamber of Commerce Dues	(40)	20	4
5	Independent Living Dietary Cost Offset	(5,974)	1	5
6	Independent Living Food Cost Offset	(5,680)	2	6
7	Independent Living Housekeeping Cost Offset	(4,622)	3	7
8	Independent Living Laundry Cost Offset	(2,518)	4	8
9	Independent Living Utilities Cost Offset	(4,084)	5	9
10	Independent Living Maintenance Cost Offset	(2,818)	6	10
11	Offset of Office Supplies Income	(75)	21	11
12	Offset of Transportation Revenue	(2,644)	11	12
13	Offset of Nursing Supplies Revenue	(452)	10	13
14	Disallowed Special Events	(11)	43	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		(60,657)	49

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark B. Petersen	100	See PG6-Supp		See PG6-Supp		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 0	\$	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	0		2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	0		3	
4	V	5 Utilities		Petersen Health Care, Inc.	100.00%	0		4	
5	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	0		5	
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6	
7	V	9 Medical Director		Petersen Health Care, Inc.	100.00%	0		7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	0		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		Petersen Health Care, Inc.	100.00%	0		11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	208	208	12	
13	V							13	
14	Total		\$			\$ 208	\$ *	208	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 56	\$	56	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	0			16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	0			17
18	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	0			18
19	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	0			19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	0			20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	0			21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0			22
23	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	809		809	23
24	V	32 Interest		Petersen Health Care, Inc.	100.00%	0			24
25	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	0			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		\$			\$ 865	\$ *	865	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health Business, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Business, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Business, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Business, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Business, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Business, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Business, LLC	100.00%	0		22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Business, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Business, LLC	100.00%	29,230	29,230	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	188	188	26
27	V	21 Clerical and General Office		Petersen Health Business, LLC	100.00%	0		27
28	V	22 Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	(121)	(121)	28
29	V	23 Inservice Training & Education		Petersen Health Business, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Business, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0		32
33	V	30 Depreciation		Petersen Health Business, LLC	100.00%	0		33
34	V	31 Amortization		Petersen Health Business, LLC	100.00%	4,900	4,900	34
35	V	32 Interest		Petersen Health Business, LLC	100.00%	17,622	17,622	35
36	V	33 Real Estate Taxes		Petersen Health Business, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0		38
39	Total		\$			\$ 51,819	\$ * 51,819	39

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

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 4,136	\$	4,136	15
16	V	2 Food		Petersen Health Care Management, Inc.	100.00%	7		7	16
17	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	32		32	17
18	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	238		238	18
19	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,640		1,640	19
20	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		0	20
21	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		0	21
22	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	126		126	22
23	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		0	23
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		0	24
25	V	17 Administrative	255,700	Petersen Health Care Management, Inc.	100.00%	89,440		(166,260)	25
26	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	7,316		7,316	26
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	131		131	27
28	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	46,368		46,368	28
29	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	31,009		31,009	29
30	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	319		319	30
31	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	72		72	31
32	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,254		3,254	32
33	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	500		500	33
34	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		0	34
35	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	7,428		7,428	35
36	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	239		239	36
37	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	542		542	37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	628		628	38
39	Total		\$ 255,700			\$ 193,425	\$ *	(62,275)	39

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Quality, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Quality, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Quality, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Quality, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Quality, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Quality, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Quality, LLC	100.00%	0		22	
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Quality, LLC	100.00%	0		23	
24	V	17 Administrative		Petersen Health Quality, LLC	100.00%	0		24	
25	V	19 Professional Services		Petersen Health Quality, LLC	100.00%	1,392	1,392	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Quality, LLC	100.00%	167	167	26	
27	V	21 Clerical and General Office		Petersen Health Quality, LLC	100.00%	0		27	
28	V	22 Employee Benefits & Payroll		Petersen Health Quality, LLC	100.00%	30	30	28	
29	V	23 Inservice Training & Education		Petersen Health Quality, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Quality, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Quality, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Quality, LLC	100.00%	0		32	
33	V	30 Depreciation		Petersen Health Quality, LLC	100.00%	0		33	
34	V	31 Amortization		Petersen Health Quality, LLC	100.00%	2,260	2,260	34	
35	V	32 Interest		Petersen Health Quality, LLC	100.00%	3,316	3,316	35	
36	V	33 Real Estate Taxes		Petersen Health Quality, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Quality, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Quality, LLC	100.00%	0		38	
39	Total		\$			\$ 7,165	\$ *	7,165	39

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

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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 J	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care	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 Frankf	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	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4								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 RHC # 0053504 Report Period Beginning: 1/1/2015 Ending: 12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,553,881	75	\$ 0	\$ 0	21,341	\$ 0	1
2	2	Food	Resident Days	1,553,881	75	0	0	21,341	0	2
3	3	Housekeeping	Resident Days	1,553,881	75	0	0	21,341	0	3
4	5	Utilities	Resident Days	1,553,881	75	0	0	21,341	0	4
5	6	Maintenance	Resident Days	1,553,881	75	0	0	21,341	0	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	21,341	0	6
7	9	Medical Director	Resident Days	1,553,881	75	0	0	21,341	0	7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	0	0	21,341	0	8
9	10A	Therapy	Resident Days	1,553,881	75	0	0	21,341	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	21,341	0	10
11	17	Administrative	Resident Days	1,553,881	75	0	0	21,341	0	11
12	19	Professional Services	Resident Days	1,553,881	75	15,159	0	21,341	208	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	4,077	0	21,341	56	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	0	0	21,341	0	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	0	0	21,341	0	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	0	0	21,341	0	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	0	0	21,341	0	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	0	0	21,341	0	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	0	0	21,341	0	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75	0	0	21,341	0	20
21	30	Depreciation	Resident Days	1,553,881	75	58,874	0	21,341	809	21
22	32	Interest	Resident Days	1,553,881	75	0	0	21,341	0	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	0	0	21,341	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	0	0	21,341	0	24
25	TOTALS					\$ 78,110	\$		\$ 1,073	25

Facility Name & ID Number Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	135,444	9		15,961		1
2	2	Food	Resident Days	135,444	9		15,961		2
3	3	Housekeeping	Resident Days	135,444	9		15,961		3
4	4	Laundry	Resident Days	135,444	9		15,961		4
5	5	Utilities	Resident Days	135,444	9		15,961		5
6	6	Maintenance	Resident Days	135,444	9		15,961		6
7	7	Mgmt. Allocation of Benefits	Resident Days	135,444	9		15,961		7
8	10	Nursing and Medical Records	Resident Days	135,444	9		15,961		8
9	15	Mgmt. Allocation of Benefits	Resident Days	135,444	9		15,961		9
10	17	Administrative	Resident Days	135,444	9		15,961		10
11	19	Professional Services	Resident Days	135,444	9	248,045	15,961	29,230	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	135,444	9	1,598	15,961	188	12
13	21	Clerical and General Office	Resident Days	135,444	9		15,961		13
14	22	Employee Benefits & Payroll	Resident Days	135,444	9	(1,030)	15,961	(121)	14
15	23	Inservice Training & Education	Resident Days	135,444	9		15,961		15
16	24	Travel and Seminar	Resident Days	135,444	9		15,961		16
17	25	Other Admin. Staff Transport.	Resident Days	135,444	9		15,961		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	135,444	9		15,961		18
19	30	Depreciation	Resident Days	135,444	9		15,961		19
20	31	Amortization	Resident Days	135,444	9	41,581	15,961	4,900	20
21	32	Interest	Resident Days	135,444	9	149,539	15,961	17,622	21
22	33	Real Estate Taxes	Resident Days	135,444	9		15,961		22
23	34	Rent-Facility and Grounds	Resident Days	135,444	9		15,961		23
24	35	Rent-Equipment & Vehicles	Resident Days	135,444	9		15,961		24
25	TOTALS					\$ 439,733	\$	\$ 51,819	25

Facility Name & ID Number Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Care Management, 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	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,553,881	75	\$ 299,960	\$ 294,997	21,341	\$ 4,136	1
2	2	Food	Resident Days	1,553,881	75	674		21,341	7	2
3	3	Housekeeping	Resident Days	1,553,881	75	2,071	558	21,341	32	3
4	5	Utilities	Resident Days	1,553,881	75	4,350		21,341	238	4
5	6	Maintenance	Resident Days	1,553,881	75	111,954	94,000	21,341	1,640	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			21,341		6
7	9	Medical Director	Resident Days	1,553,881	75			21,341		7
8	10	Nursing and Medical Records	Resident Days	1,553,881	75	1,461		21,341	126	8
9	10A	Therapy	Resident Days	1,553,881	75			21,341		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			21,341		10
11	17	Administrative	Resident Days	1,553,881	75	4,576,674	4,576,674	21,341	89,440	11
12	19	Professional Services	Resident Days	1,553,881	75	450,945		21,341	7,316	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,553,881	75	3,615		21,341	131	13
14	21	Clerical and General Office	Resident Days	1,553,881	75	3,292,042	3,146,898	21,341	46,368	14
15	22	Employee Benefits and Payroll Tax	Resident Days	1,553,881	75	1,135,675		21,341	31,009	15
16	23	Inservice Training & Education	Resident Days	1,553,881	75	1,076		21,341	319	16
17	24	Travel and Seminar	Resident Days	1,553,881	75	1,251		21,341	72	17
18	25	Other Admin. Staff Transport.	Resident Days	1,553,881	75	111,953		21,341	3,254	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,553,881	75	9,414		21,341	500	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,553,881	75			21,341		20
21	30	Depreciation	Resident Days	1,553,881	75	14,424		21,341	7,428	21
22	32	Interest	Resident Days	1,553,881	75	19,136		21,341	239	22
23	33	Real Estate Taxes	Resident Days	1,553,881	75	8,075		21,341	542	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,553,881	75	25,089		21,341	628	24
25	TOTALS					\$ 10,069,839	\$ 8,113,127		\$ 193,425	25

Facility Name & ID Number Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending: 2/31/2015

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health Quality, LLC
 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	88,147	6		5,380		1
2	2	Food	Resident Days	88,147	6		5,380		2
3	3	Housekeeping	Resident Days	88,147	6		5,380		3
4	4	Laundry	Resident Days	88,147	6		5,380		4
5	5	Utilities	Resident Days	88,147	6		5,380		5
6	6	Maintenance	Resident Days	88,147	6		5,380		6
7	7	Mgmt. Allocation of Benefits	Resident Days	88,147	6		5,380		7
8	10	Nursing and Medical Records	Resident Days	88,147	6		5,380		8
9	15	Mgmt. Allocation of Benefits	Resident Days	88,147	6		5,380		9
10	17	Administrative	Resident Days	88,147	6		5,380		10
11	19	Professional Services	Resident Days	88,147	6	22,808	5,380	1,392	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	88,147	6	2,735	5,380	167	12
13	21	Clerical and General Office	Resident Days	88,147	6		5,380		13
14	22	Employee Benefits & Payroll	Resident Days	88,147	6	498	5,380	30	14
15	23	Inservice Training & Education	Resident Days	88,147	6		5,380		15
16	24	Travel and Seminar	Resident Days	88,147	6		5,380		16
17	25	Other Admin. Staff Transport.	Resident Days	88,147	6		5,380		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	88,147	6		5,380		18
19	27	Mgmt. Allocation of Benefits	Resident Days	88,147	6		5,380		19
20	31	Amortization	Resident Days	88,147	6	37,023	5,380	2,260	20
21	32	Interest	Resident Days	88,147	6	54,335	5,380	3,316	21
22	33	Real Estate Taxes	Resident Days	88,147	6		5,380		22
23	34	Rent-Facility and Grounds	Resident Days	88,147	6		5,380		23
24	35	Rent-Equipment & Vehicles	Resident Days	88,147	6		5,380		24
25	TOTALS					\$ 117,399	\$	\$ 7,165	25

Facility Name & ID Number

Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	Bank Leumi		X	Mortgage	Varies	1/1/2015	3,325,000	\$ 2,403,716	12/31/24	Variable	\$ 106,820						
2																	
3																	
4																	
5																	
Working Capital																	
6																	
7																	
8																	
9	TOTAL Facility Related						\$ 3,325,000	\$ 2,403,716			\$ 106,820						
B. Non-Facility Related*																	
10										Interest Income Offset	(7)						
11										Home Office Allocation-PHB	17,622						
12										Home Office Allocation-PHCM	239						
13										Home Office Allocation-PHQ	3,316						
14	TOTAL Non-Facility Related						\$	\$			\$ 21,170						
15	TOTALS (line 9+line14)						\$ 3,325,000	\$ 2,403,716			\$ 127,990						

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2014 report.		\$ 16,512	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.)		\$ 16,411	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (101)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 16,908	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	542	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 17,349	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2010	15,035	8
	2011	15,225	9
	2012	15,705	10
	2013	16,032	11
	2014	16,411	12
Accrual based on prior year tax bill.			
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2014 \$	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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Robings Manor RHC COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0053504

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 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>21-001-047-00</u>	<u>Lot 12, Albro Palmers etal sub div</u>	\$ <u>6,888.12</u>	\$ <u>6,888.12</u>
2. <u>21-001-048-00</u>	<u>N Pt Lot 13 A Palmers etal sub div</u>	\$ <u>8,642.62</u>	\$ <u>8,642.62</u>
3. <u>21-001-049-00</u>	<u>40 Ctr Lot 13 A Palmers etal sub div</u>	\$ <u>879.98</u>	\$ <u>879.98</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>16,410.72</u></u>	\$ <u><u>16,410.72</u></u>

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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 RHC

0053504 Report Period Beginning:

1/1/2015 Ending:

12/31/2015

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

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

1. Total Amount Incurred: 95,556 2. Number of Years Over Which it is Being Amortized: 20
 3. Current Period Amortization: 7,160 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

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

Facility Name & ID Number Robings Manor RHC

0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	68		1977	1977	\$ 340,200	\$	25	\$	\$	\$ 340,200	4
5	7		2006	2006	1,319,360		25	35,183	35,183	351,830	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			14,285	16
17	Various		1995		18,999		20	950	950	18,205	17
18	Tile flooring		1996		991		20	42	42	991	18
19	Curtains		1996		3,187		20	159	159	3,115	19
20	Mini blinds		1996		358		20	18	18	353	20
21	Concrete parking lot		1996		1,250		20	63	63	1,222	21
22	Paving and lining parking lot		1996		8,325		20	416	416	7,940	22
23	Electrical box		1997		3,777		20	189	189	3,591	23
24	Medicare survey		1997		1,543		20	77	77	1,425	24
25	Windows		1997		1,640		20	82	82	1,517	25
26	Screen patio		1997		8,369		20	418	418	7,664	26
27	Seal coat parking lot		1997		675		20	34	34	621	27
28	Landscaping		1998		4,553		15			4,553	28
29	Remodeling		1998		1,822		20	91	91	1,593	29
30	Siding & windows		1998		39,885		20	1,994	1,994	34,896	30
31	Outdoor sign		1999		1,036		20	52	52	884	31
32	Sprinkler heads		1999		2,187		20	109	109	1,854	32
33	Handicapped bathrooms		1999		23,785		20	1,189	1,189	18,918	33
34	Nurse call system		1999		3,648		20	182	182	3,095	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 RHC

0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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

1	2	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	\$ 18,479	37
38	Fencing	1999	2,777		20	139	139	2,363	38
39	Windows	1999	1,250		20	63	63	1,070	39
40	Garage & patio	1999	15,560		20	778	778	13,226	40
41	Windows	2000	1,233		20	62	62	960	41
42	Key system	2000	1,080		20	54	54	837	42
43	Resurface parking lot	2000	1,950		20	98	98	1,518	43
44	Kitchen remodeling	2001	2,152		20	108	108	1,565	44
45	Air compressor	2001	5,900		20	295	295	4,278	45
46	Carpet	2001	1,221		20	61	61	885	46
47	New roof - shed	2001	1,320		20	66	66	957	47
48	Remodel skilled units	2001	5,897		20	295	295	4,277	48
49	Building upgrades	2002	4,937		20	247	247	3,334	49
50	Nurses station cabinets	2002	2,369		20	118	118	1,594	50
51	Gutters and drains	2003	3,400		20	170	170	2,125	51
52	Hot water heater	2003	1,932		20	97	97	1,211	52
53	Boiler/Hot Water	2004	1,525		20	76	76	875	53
54	ADT Smoke detector	2004	6,176		20	309	309	3,553	54
55	Fire Suppression System	2004	1,920		20	96	96	1,104	55
56	Landscaping Improvements	2005	11,483		20	574	574	6,027	56
57	Architect Fees	2005	7,996		20	400	400	4,200	57
58	Fire System	2006	10,250		25	410	410	3,793	58
59	Generator	2006	5,260		15	351	351	3,334	59
60	Carpeting	2007	590		10	59	59	502	60
61	HVAC in Laundry Building	2007	6,900		15	460	460	3,910	61
62	Tile Replacement	2008	11,066		15	738	738	5,535	62
63	Sprinkler Installation on Outside Porch	2009	2,600		15	174	174	1,131	63
64	Dry Pressure Valve Repair	2013	2,861		7	408	408	1,020	64
65	Generator Repair	2013	4,240		7	606	606	1,515	65
66	Sprinkler System Repair	2013	10,199		7	1,458	1,458	3,645	66
67	Hall 200 Remodeling	2014	4,945		15	330	330	495	67
68	Flooring for Front Entry Area	2014	6,893		15	460	460	690	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,080,276	\$		\$ 51,895	\$ 51,895	\$ 1,029,544	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,080,276	\$		\$ 51,895	\$ 51,895	\$ 1,029,544	1
2	Water Heater	2015	4,300		7	307	307	307	2
3	Door Alarm System	2015	3,961		7	283	283	283	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			1,304			(1,304)		26
27	Building Booked			52,774			(52,774)		27
28	Building Improvement Booked			36,917			(36,917)		28
29									29
30	2015-Home Office Allocation-Building Improvements		9,338			224	224		30
31	2015-Home Office Allocation-Land Improvements		872			56	56		31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,098,747	\$ 90,995		\$ 52,765	\$ (38,230)	\$ 1,030,134	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 54,293	\$ 3,340	\$ 4,773	\$ 1,433	5-10 yrs.	\$ 39,080	71
72	Current Year Purchases	2,806	33	140	107	10 yrs.	140	72
73	Fully Depreciated Assets	136,969					136,969	73
74	Home Office Allocation			7,957	7,957			74
75	TOTALS	\$ 194,068	\$ 3,373	\$ 12,870	\$ 9,497		\$ 176,189	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2011 Ford E350 Van	2011	39,084	\$ 7,817	\$ 7,817	\$	5 Yrs.	\$ 35,174	76
77										77
78										78
79										79
80	TOTALS			\$ 39,084	\$ 7,817	\$ 7,817	\$		\$ 35,174	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)	\$ 2,516,790	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 102,185	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 73,452	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (28,733)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,241,497	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	\$ 257,950	86
87	Independent Living-2007	15,749	1,726	14,671	87
88					88
89					89
90					90
91	TOTALS	\$ 685,749	\$ 28,526	\$ 272,621	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 RHC

0053504

Report Period Beginning: 1/1/2015

Ending: 12/31/2015

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

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 14,377 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18	<u>N/A</u>				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 RHC

0053504

Period Beginning 1/1/2015

Period End 12/31/2015

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	6,969
Dishwasher		653
Copier		6,127
Home Office Allocation		628
		<u>14,377</u>

Facility Name & ID Number Robings Manor RHC # 0053504 Report Period Beginning: 1/1/2015 Ending: 12/31/2015
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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,663	\$ 54,951	\$	3,663	\$ 54,951	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,616	39,236		2,616	39,236	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		3,830	57,449		3,830	57,449	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescripts				47,856		47,856	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$	10,109	\$ 151,636	\$ 47,856	10,109	\$ 199,492	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 RHC# 0053504Report Period Beginning: 1/1/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,709,256	\$ 2,709,256	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>110,510</u>)	950,339	950,339	3
4	Supply Inventory (priced at <u>Cost</u>)	10,964	10,964	4
5	Short-Term Investments			5
6	Prepaid Insurance	27,206	27,206	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	500	500	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,698,265	\$ 3,698,265	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	1,668,898	14
15	Leasehold Improvements, at Historical Cost	2,370,029	429,849	15
16	Equipment, at Historical Cost	237,082	233,152	16
17	Accumulated Depreciation (book methods)	(1,624,983)	(1,241,497)	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>Independent Living Facility</u>		413,128	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,573,488	\$ 1,688,421	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,271,753	\$ 5,386,686	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 658,157	\$ 658,157	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,236	6,236	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	76,396	76,396	30
31	Accrued Taxes Payable (excluding real estate taxes)	77,390	77,390	31
32	Accrued Real Estate Taxes(Sch.IX-B)	16,908	16,908	32
33	Accrued Interest Payable	10,349	10,349	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	166,704	166,704	36
37	<u>Accrued Management Fees</u>	308,440	308,440	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,320,580	\$ 1,320,580	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,403,716	2,403,716	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	6,953,687	6,953,687	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 9,357,403	\$ 9,357,403	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,677,983	\$ 10,677,983	46
47	TOTAL EQUITY (page 18, line 24)	\$ (5,406,230)	\$ (5,291,297)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,271,753	\$ 5,386,686	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 396,357	1
2	Restatements (describe):		2
3	Prior Period Adjustments Made After Cost Report Was Filed	(1,063,454)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (667,097)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	547,251	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)	\$ 547,251	17
B. Transfers (Itemize):			
18	Transfer of Net Assets Due to Corporate Restructuring	(5,286,384)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (5,286,384)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (5,406,230)	24 *

* This must agree with page 17, line 47.

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

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

		1	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,208,896	1
2	Discounts and Allowances for all Levels	(140,645)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,068,251	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	57,924	5
6	Therapy	292,266	6
7	Oxygen	397	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 350,587	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,722	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	77,738	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,696	20
21	Other Medical Services	3,059	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 86,215	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	7	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	2,644	28
28a	<u>Miscellaneous Revenue</u>	527	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,171	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,508,231	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	591,049	31
32	Health Care	1,213,181	32
33	General Administration	526,859	33
B. Capital Expense			
34	Ownership	239,561	34
C. Ancillary Expense			
35	Special Cost Centers	222,099	35
36	Provider Participation Fee	168,231	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,960,980	40
41	Income before Income Taxes (line 30 minus line 40)**	547,251	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 547,251	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,310,181	44
45	Private Pay - Net Inpatient Revenue	484,215	45
46	Medicare - Net Inpatient Revenue	260,353	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	13,845	47
48	Other-(specify) <u>Charity Contractual Allowance</u>	(343)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,068,251	49

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

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

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

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

Facility Name & ID Number **Robings Manor RHC**

0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015

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	\$ 72,866	\$ 35.03	1
2	Assistant Director of Nursing	2,080	2,080	49,957	24.02	2
3	Registered Nurses	10,341	10,668	244,120	22.88	3
4	Licensed Practical Nurses	5,548	5,601	105,886	18.90	4
5	CNAs & Orderlies	38,549	39,739	424,030	10.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	25,518	12.27	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	28,637	13.77	11
12	Dietician					12
13	Food Service Supervisor	1,694	1,694	23,511	13.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,821	11,336	102,467	9.04	15
16	Dishwashers					16
17	Maintenance Workers	1,938	2,006	31,791	15.85	17
18	Housekeepers	8,803	9,248	84,010	9.08	18
19	Laundry	5,359	5,552	49,911	8.99	19
20	Administrator	2,080	2,080	89,440	43.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,342	2,342	36,727	15.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	1,790	1,955	28,396	14.52	33
34	TOTAL (lines 1 - 33)	97,585	100,541	\$ 1,397,267 *	\$ 13.90	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 14,400	L9,C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 4,806	L10, C3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	8 484	L10A, C3	42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	8 \$ 19,690		49

C. CONTRACT NURSES

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

Robings Manor RHC

0053504

Period Beginning 1/1/2015

Period End 12/31/2015

Schedule 20A

XVIII. Staffing and Salary Costs

			Reporting Period	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Total Salaries, Wages	Average Hourly Wage
Restorative Salaries	1,787	1,952	28,363	14.53
Transportation	3	3	33	11.00
TOTAL	1,790	1,955	28,396	

Facility Name & ID Number **Robings Manor RHC**

0053504

Report Period Beginning: **1/1/2015**

Ending: **12/31/2015**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Susan Shaw	Administrator	0	\$ 89,440	Workers' Compensation Insurance	\$ 43,301	IDPH License Fee	\$ 4,574	
				Unemployment Compensation Insurance	45,806	Advertising: Employee Recruitment		
				FICA Taxes	93,462	Health Care Worker Background Check		
				Employee Health Insurance	(5,750)	(Indicate # of checks performed <u>86</u>)	1,329	
				Employee Meals		Miscellaneous Licenses & Permits	1,027	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	84	
				Employee Relations	1,131	Home Office Allocation	542	
				Employee Retirement	369			
				Home Office Allocation	30,918			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 89,440	TOTAL (agree to Schedule V, line 22, col.8)		\$ 7,516		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(40)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 255,700				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 255,700				TOTAL (agree to Sch. V, line 20, col. 8)	
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
E-Health Data Solutions	Computer Services		\$ 4,421				Out-of-State Travel	\$
AT&T	Computer Services		740					
Honkamp Krueger & Company	Accounting Fees		1,630				In-State Travel	
Consolidated Land Surveying	ALTA Survey Fees		3,000	N/A				
							Seminar Expense	
							Home Office Allocation	72
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 9,791	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 72	

* Attach copy of IMRF notifications

**See instructions.

Robings Manor RHC

0053504

Period Beginning

1/1/2015

Period End

12/31/2015

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		9,791

Home Office Allocation

Denton's US LLP	Legal	104
Applegate and Thorne	Legal	4812
Miller Hall and Triggs	Legal	16
Healthcare Resources International	Legal	85
Lexis Nexis	Legal	6
GoffWilson	Legal	712
Illinois Secretary of State	Legal	29
Lashley & Baer	Legal	349
Private Bank	Legal	60
CliftonLarson Allen	Accountants	1,376
Ginoli & Co.	Accountants	1,912
Private Bank	Accountants	296
Miscellaneous	Computer Services	52
CCH	Computer Services	12
PTC Select	Computer Services	17
Advanced Answers on Demand	Computer Services	2277
Stratus Networks	Computer Services	414
Kemper Technology	Computer Services	609
AT&T	Computer Services	5
Ability Network	Computer Services	587
CIAN	Computer Services	413
Comcast	Computer Services	16
Emdeon	Computer Services	34
Charter Communications	Computer Services	28
Allscripts	Computer Services	20

Allpayer Exchange	Computer Services	13
E-Health Technologies	Computer Services	9
Macquarie Technology Services	Computer Services	14
Optimizer	Other Prof Fees	40
D.J. Howard Appraisers	Other Prof Fees	36
Key Corporate Services	Other Prof Fees	121
Consolidated Land Surveying	Other Prof Fees	76
Alan Litwiller	Other Prof Fees	16
Marotta Gund Budd Derza	Other Prof Fees	23568
Registered Agent Services	Other Prof Fees	12

Total (agree to Schedule V, line 19, column 8)	<u><u>47,937</u></u>
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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	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6	N/A											
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Robings Manor RHC# 0053504

Report Period Beginning:

1/1/2015

Ending:

12/31/2015**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,404 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
-
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 168,231
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. \$ 1,722
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 2,644
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? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Robings Manor Rehab & Health Care
 0026716
 Period Beginning 1/1/2015
 Period End 12/31/2015

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	970	4.35%
Nursing Home	21,341	95.65%
	<u>22,311</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	137,416	4.35%	5,974	Census	1
Food	130,652	4.35%	5,680	Census	2
Housekeeping	106,301	4.35%	4,622	Census	3
Laundry	57,923	4.35%	2,518	Census	4
Utilities	93,946	4.35%	4,084	Census	5
Maintenance	64,811	4.35%	2,818	Census	6
Depreciation (Building)	<u>28,526</u>	100.00%	<u>28,526</u>	Beds	30
Total	<u>619,575</u>		<u>54,223</u>		

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.