

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center

0047555 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		Medicaid Recipient	Private Pay	Other		
8	SNF					8
9	SNF/PED					9
10	ICF	7,946	5,648		13,594	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,946	5,648		13,594	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.12%

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

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

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 10/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/01/05 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number

Sandwich Rehabilitation & Health Care Cent

0047555

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	113,530	6,887	1,680	122,097		122,097	(39,618)	82,479		1
2	Food Purchase		99,770		99,770		99,770	(35,341)	64,429		2
3	Housekeeping	91,606	7,809		99,415		99,415	(34,474)	64,941		3
4	Laundry	19,179	7,731		26,910		26,910	(9,334)	17,576		4
5	Heat and Other Utilities			78,977	78,977		78,977	(27,203)	51,774		5
6	Maintenance	20,096	4,875	26,489	51,460		51,460	(16,255)	35,205		6
7	Other (specify):* Home Off. Ben. All.							1,853	1,853		7
8	TOTAL General Services	244,411	127,072	107,146	478,629		478,629	(160,372)	318,257		8
	B. Health Care and Programs										
9	Medical Director			14,700	14,700		14,700		14,700		9
10	Nursing and Medical Records	615,288	40,564	17,218	673,070		673,070	4,888	677,958		10
10a	Therapy			856	856		856		856		10a
11	Activities	22,007	332	683	23,022		23,022		23,022		11
12	Social Services	14,822			14,822		14,822		14,822		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							2,233	2,233		15
16	TOTAL Health Care and Programs	652,117	40,896	33,457	726,470		726,470	7,121	733,591		16
	C. General Administration										
17	Administrative	43,429		33,000	76,429		76,429	(17,998)	58,431		17
18	Directors Fees										18
19	Professional Services			7,058	7,058		7,058	4,186	11,244		19
20	Dues, Fees, Subscriptions & Promotions			9,290	9,290		9,290	130	9,420		20
21	Clerical & General Office Expenses	26,448	4,000	8,857	39,305		39,305	21,026	60,331		21
22	Employee Benefits & Payroll Taxes			156,146	156,146		156,146		156,146		22
23	Inservice Training & Education							222	222		23
24	Travel and Seminar							353	353		24
25	Other Admin. Staff Transportation			1,849	1,849		1,849	2,300	4,149		25
26	Insurance-Prop.Liab.Malpractice			13,698	13,698		13,698	521	14,219		26
27	Other (specify):* Home Off. Ben. All.							10,963	10,963		27
28	TOTAL General Administration	69,877	4,000	229,898	303,775		303,775	21,703	325,478		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	966,405	171,968	370,501	1,508,874		1,508,874	(131,548)	1,377,326		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

Sandwich Rehabilitation & Health Care Center

#0047555

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7**	8		
30	Depreciation			20,983	20,983		20,983	238	21,221		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			30,570	30,570		30,570	30,404	60,974		32
33	Real Estate Taxes			65,240	65,240		65,240	445	65,685		33
34	Rent-Facility & Grounds							27	27		34
35	Rent-Equipment & Vehicles			5,194	5,194		5,194	358	5,552		35
36	Other (specify):*										36
37	TOTAL Ownership			121,987	121,987		121,987	31,472	153,459		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		50		50		50		50		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			34,493	34,493		34,493		34,493		42
43	Other (specify):* Non-allowable Cost	5,098	315	9,414	14,827		14,827	(14,827)			43
44	TOTAL Special Cost Centers	5,098	365	43,907	49,370		49,370	(14,827)	34,543		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	971,503	172,333	536,395	1,680,231		1,680,231	(114,903)	1,565,328		45

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

**See schedule of adjustments attached at end of cost report.

Sandwich Rehabilitation & Health Care CenterID# 0047555Report Period Beginning: 01/01/2007Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Offset Miscellaneous Office Supplies Revenue	\$ (93)	21	1
2	Independent Living depreciation offset	(2,007)	30	2
3	Independent Living - Dietary	(42,355)	1	3
4	Independent Living - Food	(34,610)	2	4
5	Independent Living - Housekeeping	(34,487)	3	5
6	Independent Living - Laundry	(9,335)	4	6
7	Independent Living - Utilities	(27,397)	5	7
8	Independent Living - Maintenance	(17,851)	6	8
9	Nonallowable dues	(410)	20	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
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	(168,545)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center# 0047555

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(42,355)	1,138	0	1,599	0	0	0	0	0	0	0	(39,618)	1
2	Food Purchase	(35,380)	39	0	0	0	0	0	0	0	0	0	(35,341)	2
3	Housekeeping	(34,487)	13	0	0	0	0	0	0	0	0	0	(34,474)	3
4	Laundry	(9,335)	1	0	0	0	0	0	0	0	0	0	(9,334)	4
5	Heat and Other Utilities	(27,397)	194	0	0	0	0	0	0	0	0	0	(27,203)	5
6	Maintenance	(17,851)	1,585	0	11	0	0	0	0	0	0	0	(16,255)	6
7	Other (specify):*	0	519	0	1,334	0	0	0	0	0	0	0	1,853	7
8	TOTAL General Services	(166,805)	3,489	0	2,944	0	(160,372)	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	3,008	0	1,880	0	0	0	0	0	0	0	4,888	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	669	0	1,564	0	0	0	0	0	0	0	2,233	15
16	TOTAL Health Care and Program	0	3,677	0	3,444	0	7,121	16						
	C. General Administration													
17	Administrative	0	(24,532)	0	6,534	0	0	0	0	0	0	0	(17,998)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,299	0	1,887	0	0	0	0	0	0	0	4,186	19
20	Fees, Subscriptions & Promotions	(410)	0	498	42	0	0	0	0	0	0	0	130	20
21	Clerical & General Office Expenses	(93)	0	19,282	1,837	0	0	0	0	0	0	0	21,026	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	222	0	0	0	0	0	0	0	0	222	23
24	Travel and Seminar	0	0	353	0	0	0	0	0	0	0	0	353	24
25	Other Admin. Staff Transportation	0	0	1,279	1,021	0	0	0	0	0	0	0	2,300	25
26	Insurance-Prop.Liab.Malpractice	0	0	521	0	0	0	0	0	0	0	0	521	26
27	Other (specify):*	0	0	5,513	5,450	0	0	0	0	0	0	0	10,963	27
28	TOTAL General Administration	(503)	(22,233)	27,668	16,771	0	21,703	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(167,308)	(15,067)	27,668	23,159	0	(131,548)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(1,883)	0	1,350	771	0	0	0	0	0	0	0	238	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(760)	0	2,347	28,817	0	0	0	0	0	0	0	30,404	32
33	Real Estate Taxes	0	0	445	0	0	0	0	0	0	0	0	445	33
34	Rent-Facility & Grounds	0	0	27	0	0	0	0	0	0	0	0	27	34
35	Rent-Equipment & Vehicles	0	0	358	0	0	0	0	0	0	0	0	358	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,643)	0	4,527	29,588	0	31,472	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(14,827)	0	0	0	0	0	0	0	0	0	0	(14,827)	43
44	TOTAL Special Cost Centers	(14,827)	0	0	0	0	0	0	0	0	0	0	(14,827)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(184,778)	(15,067)	32,195	52,747	0	(114,903)	45						

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See Attached Schedule 6E		See Attached Sch 6E		

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 1,138	\$ 1,138	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	39	39	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	13	13	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	194	194	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,585	1,585	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	519	519	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	3,008	3,008	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%	669	669	10
11	V	17 Administrative	33,000	Petersen Health Care, Inc.	100.00%	8,468	(24,532)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,299	2,299	12
13	V							13
14	Total		\$ 33,000			\$ 17,933	\$ * (15,067)	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 and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 498	\$ 498	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	19,282	19,282	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	222	222	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	353	353	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,279	1,279	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	521	521	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	5,513	5,513	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,350	1,350	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,347	2,347	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	445	445	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	27	27	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	358	358	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		\$			\$ 32,195	\$ * 32,195	39

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

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center# 0047555Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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 <u>Dietary</u>	\$	<u>Petersen Health Operations, LLC</u>	100.00%	\$ 1,599	\$	1,599	15
16	V	2 <u>Food</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	16
17	V	3 <u>Housekeeping</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	17
18	V	4 <u>Laundry</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	18
19	V	5 <u>Utilities</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	19
20	V	6 <u>Maintenance</u>		<u>Petersen Health Operations, LLC</u>	100.00%	11		11	20
21	V	7 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,334		1,334	21
22	V	10 <u>Nursing and Medical Records</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,880		1,880	22
23	V	10A <u>Therapy</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	23
24	V	15 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,564		1,564	24
25	V	17 <u>Administrative</u>		<u>Petersen Health Operations, LLC</u>	100.00%	6,534		6,534	25
26	V	19 <u>Professional Services</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,887		1,887	26
27	V	20 <u>Dues, Fees, Subs and Promotions</u>		<u>Petersen Health Operations, LLC</u>	100.00%	42		42	27
28	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,837		1,837	28
29	V	23 <u>Inservice Training and Education</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	29
30	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	30
31	V	25 <u>Other Admin. Staff Transportation</u>		<u>Petersen Health Operations, LLC</u>	100.00%	1,021		1,021	31
32	V	26 <u>Insurance-Prop./Liab/Malpractice</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	32
33	V	27 <u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Operations, LLC</u>	100.00%	5,450		5,450	33
34	V	30 <u>Depreciation</u>		<u>Petersen Health Operations, LLC</u>	100.00%	771		771	34
35	V	32 <u>Interest</u>		<u>Petersen Health Operations, LLC</u>	100.00%	28,817		28,817	35
36	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	36
37	V	34 <u>Rent-Facility and Grounds</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	37
38	V	35 <u>Rent-Equipment and Vehicles</u>		<u>Petersen Health Operations, LLC</u>	100.00%	0		0	38
39	Total		\$			\$ 52,747	\$ *	52,747	39

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

Facility Name & ID Number Sandwich Rehabilitation & Health Care Cen # 0047555 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.56	1.01	Salary	\$ 8,468	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 8,468		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 Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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	1,316,550	66	\$ 110,171	\$ 109,587	13,594	\$ 1,138	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	13,594	39	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	13,594	13	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	13,594	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	13,594	194	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	13,594	1,585	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	13,594	519	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	13,594	3,008	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	13,594	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	13,594	669	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	13,594	8,468	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	13,594	2,299	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	13,594	498	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	13,594	19,282	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	13,594	222	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	13,594	353	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	13,594	1,279	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	13,594	521	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	13,594	5,513	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	13,594	1,350	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	13,594	2,347	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	13,594	445	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	13,594	27	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	13,594	358	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 50,128	25

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/2007 Ending: 2/31/2007

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 Operations, 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	440,525	23	\$ 51,832	\$ 51,832	13,594	\$ 1,599	1
2	2	Food	Resident Days	440,525	23			13,594		2
3	3	Housekeeping	Resident Days	440,525	23			13,594		3
4	4	Laundry	Resident Days	440,525	23			13,594		4
5	5	Utilities	Resident Days	440,525	23			13,594		5
6	6	Maintenance	Resident Days	440,525	23	358		13,594	11	6
7	7	Mgmt. Allocation of Benefits	Resident Days	440,525	23	43,237		13,594	1,334	7
8	10	Nursing and Medical Records	Resident Days	440,525	23	60,910	60,761	13,594	1,880	8
9	10A	Therapy	Resident Days	440,525	23			13,594		9
10	15	Mgmt. Allocation of Benefits	Resident Days	440,525	23	50,681		13,594	1,564	10
11	17	Administrative	Resident Days	440,525	23	211,751	211,751	13,594	6,534	11
12	19	Professional Services	Resident Days	440,525	23	61,162		13,594	1,887	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	440,525	23	1,373		13,594	42	13
14	21	Clerical and General Office	Resident Days	440,525	23	59,529		13,594	1,837	14
15	23	Inservice Training & Education	Resident Days	440,525	23			13,594		15
16	24	Travel and Seminar	Resident Days	440,525	23	10		13,594		16
17	25	Other Admin. Staff Transport.	Resident Days	440,525	23	33,098		13,594	1,021	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	440,525	23			13,594		18
19	27	Mgmt. Allocation of Benefits	Resident Days	440,525	23	176,624		13,594	5,450	19
20	30	Depreciation	Resident Days	440,525	23	24,996		13,594	771	20
21	32	Interest	Resident Days	440,525	23	933,842		13,594	28,817	21
22	33	Real Estate Taxes	Resident Days	440,525	23			13,594		22
23	34	Rent-Facility and Grounds	Resident Days	440,525	23			13,594		23
24	35	Rent-Equipment & Vehicles	Resident Days	440,525	23			13,594		24
25	TOTALS					\$ 1,709,403	\$ 324,344		\$ 52,747	25

Facility Name & ID Number Sandwich Rehabilitation & Health Care Cent # 0047555 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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**					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	LaSalle Bank		X	Mortgage	Varies	1/19/07	\$ 400,000	\$ 397,271	12/31/13	Varies	\$ 30,570					
2																
3							Offset Interest Income				(760)					
4							Home Office Allocation				31,164					
5																
Working Capital																
6																
7																
8																
9	TOTAL Facility Related						\$ 400,000	\$ 397,271			\$ 60,974					
B. Non-Facility Related*																
10																
11																
12																
13																
14	TOTAL Non-Facility Related						\$	\$			\$					
15	TOTALS (line 9+line14)						\$ 400,000	\$ 397,271			\$ 60,974					

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sandwich Rehabilitation & Health Care Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0047555

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 2006 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 2006.

(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>19-25-252-015</u>	<u>Long-Term Care Facility</u>	\$ <u>33,229.94</u>	\$ <u>33,229.94</u>
2. <u>19-25-252-016</u>	<u>Long-Term Care Facility</u>	\$ <u>28,010.46</u>	\$ <u>28,010.46</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>61,240.40</u>	\$ <u>61,240.40</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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,626 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

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

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

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

Independent Living

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>94,961</u>	<u>2005</u>	<u>\$ 12,150</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	94,961		\$ 12,150	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	63	2005	1973	\$ 157,386	\$	25	\$ 6,295	\$ 6,295	\$ 15,738
5									
6									
7	Home Office Allocation			7,579			185	185	
8									
Improvement Type**									
9									
10	Original Land Improvements	2005		10,000		15	667	667	1,667
11	Sidewalks	2006		8,685		15	579	579	772
12	Remodel Nurses Station	2007		11,351		15	378	378	378
13									
14									
15									
16									
17	Land Improvements Booked				1,245			(1,245)	
18	Building Booked				8,327			(8,327)	
19	Building Improvements Booked				916			(916)	
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31	2007-Home Office Allocation-Building Improvements			507			30	30	
32									
33									
34									
35									
36									

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 195,508	\$ 10,488		\$ 8,134	\$ (2,354)	\$ 18,555	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 56,462	\$ 9,396	\$ 10,832	\$ 1,436	3-7	\$ 23,921	71
72	Current Year Purchases	6,973	1,099	349	(750)		349	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,906	1,906			74
75	TOTALS	\$ 63,435	\$ 10,495	\$ 13,087	\$ 2,592		\$ 24,270	75

D. Vehicle Depreciation (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				\$	\$	\$			\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$			\$	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)	\$ 271,093	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,983	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 21,221	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 238	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 42,825	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 (2005)	\$ 49,964	\$ 2,007	\$ 5,016	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 49,964	\$ 2,007	\$ 5,016	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6		<u>Home Office Allocation</u>			<u>27</u>			6
7	TOTAL				\$ <u>27</u>			7

**

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 5,552

Description: See Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

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. _____ /2008 \$ _____

13. _____ /2009 \$ _____

14. _____ /2010 \$ _____

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.

Sandwich Rehabilitation & Health Care Center
0047555

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 3,509
Dishwasher	673
Medical Equipment	1,012
Home Office Allocation	358
	<u>5,552</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</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. CLINICAL PORTION:</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			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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		6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)							
					Units	Cost						
1	Licensed Occupational Therapist	L. 10A, C. 3	hrs	\$	8	\$ 118				8	\$ 118	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		16	237				16	237	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	L. 10A, C. 3	hrs		33	501				33	501	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	L. 39, C. 2	# of prescrpts					50			50	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	Other (specify):											13
14	TOTAL			\$	57	\$ 856		\$ 50		57	\$ 906	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 **Sandwich Rehabilitation & Health Care Center**# **0047555**Report Period Beginning: **01/01/2007**Ending: **12/31/2007****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2007**

(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	\$ 335,867	\$ 335,867	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>N/A</u>)	112,223	112,223	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	11,794	11,794	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(66,816)	(66,816)	8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 393,068	\$ 393,068	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		12,150	13
14	Buildings, at Historical Cost	238,185	165,472	14
15	Leasehold Improvements, at Historical Cost	11,351	30,036	15
16	Equipment, at Historical Cost	63,435	63,435	16
17	Accumulated Depreciation (book methods)	(42,253)	(42,825)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 270,718	\$ 228,268	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 663,786	\$ 621,336	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 120,606	\$ 120,606	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	18,728	18,728	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,620	5,620	31
32	Accrued Real Estate Taxes(Sch.IX-B)	64,000	64,000	32
33	Accrued Interest Payable	2,483	2,483	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholding Liabilities	15,905	15,905	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 227,342	\$ 227,342	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	397,271	397,271	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Security Deposits	18,803	18,803	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 416,074	\$ 416,074	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 643,416	\$ 643,416	46
47	TOTAL EQUITY(page 18, line 24)	\$ 20,370	\$ (22,080)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 663,786	\$ 621,336	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (16,492)	1
2	Restatements (describe):		2
3	Rounding	3	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (16,489)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	36,859	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)	\$ 36,859	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 20,370	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,715,467	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,715,467	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	770	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 770	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	760	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 760	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue</u>	93	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 93	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,717,090	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	478,629	31
32	Health Care	726,470	32
33	General Administration	303,775	33
B. Capital Expense			
34	Ownership	121,987	34
C. Ancillary Expense			
35	Special Cost Centers	14,877	35
36	Provider Participation Fee	34,493	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,680,231	40
41	Income before Income Taxes (line 30 minus line 40)**	36,859	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 36,859	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. Facility is a division of a larger entity.

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

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

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center

0047555

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

12/31/2007

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,891	1,891	\$ 59,829	\$ 31.64	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,538	4,602	116,263	25.26	3
4	Licensed Practical Nurses	5,138	5,194	125,597	24.18	4
5	CNAs & Orderlies	21,414	21,964	259,561	11.82	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,445	1,506	17,092	11.35	9
10	Activity Assistants	592	592	4,915	8.30	10
11	Social Service Workers	1,202	1,218	14,822	12.17	11
12	Dietician					12
13	Food Service Supervisor	2,049	2,169	34,376	15.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,456	9,110	79,154	8.69	15
16	Dishwashers					16
17	Maintenance Workers	1,378	1,421	20,096	14.14	17
18	Housekeepers	9,157	9,605	91,606	9.54	18
19	Laundry	2,482	2,591	19,179	7.40	19
20	Administrator	1,549	1,589	43,429	27.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,975	2,180	26,448	12.13	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: Care Plan Coordir	2,107	2,227	54,038	24.26	32
33	Other(specify) <u>Marketing</u>	325	325	5,098	15.69	33
34	TOTAL (lines 1 - 33)	65,698	68,184	\$ 971,503 *	\$ 14.25	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	Monthly	\$ 1,680	L. 1, C. 3	35
36	Medical Director	Monthly	14,700	L. 9, C. 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	495	L. 10, C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,875		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	293	\$ 16,723	L. 10, C. 3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	293	\$ 16,723		53

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	
Judith Wright	Administrator	0	\$ 26,901	Workers' Compensation Insurance	\$ 10,898	IDPH License Fee	\$ 340	
Kathleen Heuertz	Administrator	0	16,528	Unemployment Compensation Insurance	40,204	Advertising: Employee Recruitment	4,029	
				FICA Taxes	73,574	Health Care Worker Background Check	470	
				Employee Health Insurance	26,859	(Indicate # of checks performed <u>47</u>)		
				Employee Meals		IHCA Dues	2,043	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Licenses	808	
						LTC Solutions License	1,600	
						Home Office Allocation	540	
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Retirement	618			
(List each licensed administrator separately.)			\$ 43,429	Employee Relations	3,993			
B. Administrative - Other								
Description			Amount			Less: Public Relations Expense	(410)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 33,000			Non-allowable advertising	()	
						Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 33,000	TOTAL (agree to Schedule V, line 22, col.8)	\$ 156,146	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 9,420	
(Attach a copy of any management service agreement)								
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		\$ 2,025				Out-of-State Travel	\$
Comcast	Computer Services		603					
McGladrey & Pullen, LLC	Accounting		4,430	N/A			In-State Travel	
							Seminar Expense	
							Home Office Allocation	353
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 7,058				TOTAL	\$ 353

* Attach copy of IMRF notifications

**See instructions.

Sandwich Rehabilitation & Health Care Center
0047555
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		7,058

Non-allowable legal expense

Home Office Allocation
Petersen Health Care, Inc

Pearl & Associates	Legal	15
Addy Bush & Assoc	Legal	8
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	33
Duane Morris	Legal	52
Ginoli & Co.	Accountants	526
RSM McGladrey	Accountants	91
McGladrey & Pullen	Accountants	139
Emdeon Business Services	Computer Services	36
Advanced Answers on Demand	Computer Services	975
Access 2 Go	Computer Services	74
Ivans	Computer Services	65
Kemper Technology	Computer Services	153
Adminastar Federal	Computer Services	19
Logmeln	Computer Services	12
E-Health Data Solutions	Computer Services	96
Miscellaneous Vendors	Miscellaneous	4

Petersen Health Operations, LLC

Ginoli & Co.	Accountants	1,167
Julie Breedlove	Computer Services	11
Ivans	Computer Services	262
Miscellaneous Vendors	Computer Services	5
Amerisearch	Employment fees	442

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>11,244</u>
--	---------------

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center# 0047555Report Period Beginning: 01/01/2007 Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA \$2043
- (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. \$ 14,522 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 34,493
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? Yes 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. \$ 770
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
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? N/A
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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Co. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Sandwich Rehabilitation & Health Care Center
 0047555
 Period Beginning 01/01/2007
 Period End 12/31/2007

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%	Beds	%
Independent Living	7,221	34.69%	20	24.10%
Nursing Home	13,594	65.31%	63	75.90%
	<u>20,815</u>	<u>100.00%</u>	<u>83</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	122,097	34.69%	42,355	Census	1
Food	99,770	34.69%	34,610	Census	2
Housekeeping	99,415	34.69%	34,487	Census	3
Laundry	26,910	34.69%	9,335	Census	4
Utilities	78,977	34.69%	27,397	Census	5
Maintenance	51,460	34.69%	17,851	Census	6
Depreciation (Building)	<u>8,327</u>	24.10%	<u>2,007</u>	Beds	30
Total	<u>486,956</u>		<u>168,042</u>		

Building Cost Offset:

P12 Building Cost	207,350	24.10%	49,964	Beds
-------------------	---------	--------	--------	------

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 cost have been offset on P5A.