

Facility Name & ID Number Sandwich Rehab & HCC

0047555 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			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 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,267	5,525	1,703	16,495	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,267	5,525	1,703	16,495	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.73%

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 10/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES Date 10/1/2005 NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 30 and days of care provided 1,414

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2013 Fiscal Year: 12/31/2013

* 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	112,328	11,853	912	125,093		125,093	(31,851)	93,242		1
2	Food Purchase		145,797		145,797		145,797	(41,126)	104,671		2
3	Housekeeping	110,921	12,839		123,760		123,760	(34,695)	89,065		3
4	Laundry	21,980	13,036		35,016		35,016	(9,825)	25,191		4
5	Heat and Other Utilities			84,565	84,565		84,565	(25,057)	59,508		5
6	Maintenance	32,128	15,330	34,692	82,150		82,150	(21,459)	60,691		6
7	Other (specify):* Home Off. Ben. All.							184	184		7
8	TOTAL General Services	277,357	198,855	120,169	596,381		596,381	(163,829)	432,552		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	914,063	85,658	6,482	1,006,203		1,006,203	(385)	1,005,818		10
10a	Therapy			188,290	188,290		188,290		188,290		10a
11	Activities	28,900	277	1,579	30,756		30,756	(1,910)	28,846		11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	942,963	85,935	213,151	1,242,049		1,242,049	(2,295)	1,239,754		16
	C. General Administration										
17	Administrative			252,000	252,000		252,000	(184,364)	67,636		17
18	Directors Fees										18
19	Professional Services			12,997	12,997		12,997	86,257	99,254		19
20	Dues, Fees, Subscriptions & Promotions			3,004	3,004		3,004	956	3,960		20
21	Clerical & General Office Expenses	28,956	2,874	27,103	58,933		58,933	43,317	102,250		21
22	Employee Benefits & Payroll Taxes			193,671	193,671		193,671	(19)	193,652		22
23	Inservice Training & Education							65	65		23
24	Travel and Seminar							3	3		24
25	Other Admin. Staff Transportation			11,377	11,377		11,377	3,009	14,386		25
26	Insurance-Prop.Liab.Malpractice			25,291	25,291		25,291	581	25,872		26
27	Other (specify):* Home Off. Ben. All.							3,729	3,729		27
28	TOTAL General Administration	28,956	2,874	525,443	557,273		557,273	(46,466)	510,807		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,249,276	287,664	858,763	2,395,703		2,395,703	(212,590)	2,183,113		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 Rehab & HCC

#0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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			20,821	20,821		20,821	1,611	22,432			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,774	10,774		10,774	24,227	35,001			32
33	Real Estate Taxes			57,848	57,848		57,848	261	58,109			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,145	26,145		26,145	481	26,626			35
36	Other (specify):*											36
37	TOTAL Ownership			115,588	115,588		115,588	26,580	142,168			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,094		81,094		81,094		81,094			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			125,859	125,859		125,859		125,859			42
43	Other (specify):* Non-allowable Costs	29,637	476	177,013	207,126		207,126	(207,126)				43
44	TOTAL Special Cost Centers	29,637	81,570	302,872	414,079		414,079	(207,126)	206,953			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,278,913	369,234	1,277,223	2,925,370		2,925,370	(393,136)	2,532,234			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(285)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,633)	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	766	30		9
10	Interest and Other Investment Income	(8,899)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	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	(88,242)	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	(66,684)	43		24
25	Fund Raising, Advertising and Promotional	(31,345)	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	(185,664)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (388,995)		\$	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)	(4,141)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (4,141)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (393,136)		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

Sandwich Rehab & HCCID# 0047555Report Period Beginning: 1/1/2013Ending: 12/31/2013

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Chamber of Commerce Dues	\$ (165)	20	1
2	Offset Miscellaneous Office Supplies Revenue	(54)	21	2
3	Disallowed Special Events	150	43	3
4	Independent Living depreciation offset	(2,007)	30	4
5	Independent Living - Dietary	(35,101)	1	5
6	Independent Living - Food	(40,911)	2	6
7	Independent Living - Housekeeping	(34,727)	3	7
8	Independent Living - Laundry	(9,825)	4	8
9	Independent Living - Maintenance	(23,051)	6	9
10	Independent Living - Utilities	(23,729)	5	10
11	Labs-Part A	(8,646)	43	11
12	X-Rays-Part A	(2,603)	43	12
13	Offset Transportation Revenue	(1,910)	21	13
14	Offset Miscellaneous Nursing Supplies Revenue	(396)	10	14
15	Offset NICOR Gas Refund Check	(1,575)	5	15
16	Resident Flowers	(155)	43	16
17	Disallowed Air Travel Expense	(959)	43	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		(185,664)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sandwich Rehab & HCC# 0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(35,101)	3,250	0	0	0	0	0	0	0	0	0	(31,851)	1
2	Food Purchase	(40,911)	70	0	0	0	0	0	0	0	0	0	(40,841)	2
3	Housekeeping	(34,727)	32	0	0	0	0	0	0	0	0	0	(34,695)	3
4	Laundry	(9,825)	0	0	0	0	0	0	0	0	0	0	(9,825)	4
5	Heat and Other Utilities	(25,304)	247	0	0	0	0	0	0	0	0	0	(25,057)	5
6	Maintenance	(23,051)	1,592	0	0	0	0	0	0	0	0	0	(21,459)	6
7	Other (specify):*	0	184	0	0	0	0	0	0	0	0	0	184	7
8	TOTAL General Services	(168,919)	5,375	0	0	0	0	0	0	0	0	0	(163,544)	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	(396)	11	0	0	0	0	0	0	0	0	0	(385)	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	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(396)	11	0	0	0	0	0	0	0	0	0	(385)	16
	C. General Administration													
17	Administrative	0	(184,364)	0	0	0	0	0	0	0	0	0	(184,364)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,853	0	79,404	0	0	0	0	0	0	0	86,257	19
20	Fees, Subscriptions & Promotions	(165)	0	436	685	0	0	0	0	0	0	0	956	20
21	Clerical & General Office Expenses	(1,964)	0	40,282	3,089	0	0	0	0	0	0	0	41,407	21
22	Employee Benefits & Payroll Taxes	0	0	0	(19)	0	0	0	0	0	0	0	(19)	22
23	Inservice Training & Education	0	0	65	0	0	0	0	0	0	0	0	65	23
24	Travel and Seminar	0	0	3	0	0	0	0	0	0	0	0	3	24
25	Other Admin. Staff Transportation	0	0	3,009	0	0	0	0	0	0	0	0	3,009	25
26	Insurance-Prop.Liab.Malpractice	0	0	581	0	0	0	0	0	0	0	0	581	26
27	Other (specify):*	0	0	3,729	0	0	0	0	0	0	0	0	3,729	27
28	TOTAL General Administration	(2,129)	(177,511)	48,105	83,159	0	(48,376)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(171,444)	(172,125)	48,105	83,159	0	(212,305)	29						

STATE OF ILLINOIS

Facility Name & ID Number Sandwich Rehab & HCC# 0047555

Report Period Beginning:

1/1/2013 Ending:

Summary B

12/31/2013

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	(10,640)	0	2,670	182	0	0	0	0	0	0	0	(7,788)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	4,442	28,684	0	0	0	0	0	0	0	33,126	32
33	Real Estate Taxes	0	0	261	0	0	0	0	0	0	0	0	261	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	481	0	0	0	0	0	0	0	0	481	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(10,640)	0	7,854	28,866	0	26,080	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):*	(11,447)	0	0	0	0	0	0	0	0	0	0	(11,447)	43
44	TOTAL Special Cost Centers	(11,447)	0	0	0	0	0	0	0	0	0	0	(11,447)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(193,531)	(172,125)	55,959	112,025	0	0	0	0	0	0	0	(197,672)	45

VII. RELATED PARTIES

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

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

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

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

1 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%	\$ 3,250	\$ 3,250	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	70	70	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	32	32	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	247	247	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,592	1,592	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	184	184	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	11	11	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	252,000	Petersen Health Care, Inc.	100.00%	67,636	(184,364)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	6,853	6,853	12
13	V							13
14	Total		\$ 252,000			\$ 79,875	\$ * (172,125)	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%	\$ 436	\$	436	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	40,282		40,282	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	65		65	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	3		3	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,009		3,009	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	581		581	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	3,729		3,729	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,670		2,670	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,442		4,442	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	261		261	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	481		481	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		\$			\$ 55,959	\$ *	55,959	39

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

Facility Name & ID Number

Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending: 12/31/2013

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 Operations, LLC	100.00%	\$ 0	\$	15
16	V	2 Food		Petersen Health Operations, LLC	100.00%	0		16
17	V	3 Housekeeping		Petersen Health Operations, LLC	100.00%	0		17
18	V	4 Laundry		Petersen Health Operations, LLC	100.00%	0		18
19	V	5 Utilities		Petersen Health Operations, LLC	100.00%	0		19
20	V	6 Maintenance		Petersen Health Operations, LLC	100.00%	0		20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		21
22	V	10 Nursing and Medical Records		Petersen Health Operations, LLC	100.00%	0		22
23	V	12 Social Services		Petersen Health Operations, LLC	100.00%	0		23
24	V	17 Administrative		Petersen Health Operations, LLC	100.00%	0		24
25	V	19 Professional Services		Petersen Health Operations, LLC	100.00%	79,404	79,404	25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	685	685	26
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	3,089	3,089	27
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	(19)	(19)	28
29	V	23 Inservice Training & Education		Petersen Health Operations, LLC	100.00%	0		29
30	V	24 Travel and Seminar		Petersen Health Operations, LLC	100.00%	0		30
31	V	25 Other Admin. Staff Transport.		Petersen Health Operations, LLC	100.00%	0		31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Operations, LLC	100.00%	0		32
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Operations, LLC	100.00%	0		33
34	V	30 Depreciation		Petersen Health Operations, LLC	100.00%	182	182	34
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	28,684	28,684	35
36	V	33 Real Estate Taxes		Petersen Health Operations, LLC	100.00%	0		36
37	V	34 Rent-Facility and Grounds		Petersen Health Operations, LLC	100.00%	0		37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Operations, LLC	100.00%	0		38
39	Total		\$			\$ 112,025	\$ *	112,025 39

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

Facility Name & ID Number

Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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 Restaurants,	Peoria	Restaurant	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	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				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

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										3
4	N/A									4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

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

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

Facility Name & ID Number Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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	1,560,986	75	\$ 307,592	\$ 295,212	16,495	\$ 3,250	1
2	2	Food	Resident Days	1,560,986	75	6,577	0	16,495	70	2
3	3	Housekeeping	Resident Days	1,560,986	75	3,057	0	16,495	32	3
4	4	Laundry	Resident Days	1,560,986	75	0	0	16,495	0	4
5	5	Utilities	Resident Days	1,560,986	75	23,338	0	16,495	247	5
6	6	Maintenance	Resident Days	1,560,986	75	150,672	97,358	16,495	1,592	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	17,394	0	16,495	184	7
8	10	Nursing and Medical Records	Resident Days	1,560,986	75	1,082	0	16,495	11	8
9	10A	Therapy	Resident Days	1,560,986	75	0	0	16,495	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	0	0	16,495	0	10
11	17	Administrative	Resident Days	1,560,986	75	4,578,456	4,578,456	16,495	67,636	11
12	19	Professional Services	Resident Days	1,560,986	75	648,504	0	16,495	6,853	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,560,986	75	41,231	0	16,495	436	13
14	21	Clerical and General Office	Resident Days	1,560,986	75	3,812,055	3,383,297	16,495	40,282	14
15	23	Inservice Training & Education	Resident Days	1,560,986	75	6,148	0	16,495	65	15
16	24	Travel and Seminar	Resident Days	1,560,986	75	313	0	16,495	3	16
17	25	Other Admin. Staff Transport.	Resident Days	1,560,986	75	284,745	0	16,495	3,009	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,560,986	75	54,993	0	16,495	581	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,560,986	75	352,851	0	16,495	3,729	19
20	30	Depreciation	Resident Days	1,560,986	75	252,711	0	16,495	2,670	20
21	32	Interest	Resident Days	1,560,986	75	420,365	0	16,495	4,442	21
22	33	Real Estate Taxes	Resident Days	1,560,986	75	24,742	0	16,495	261	22
23	34	Rent-Facility and Grounds	Resident Days	1,560,986	75	0	0	16,495	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,560,986	75	45,546	0	16,495	481	24
25	TOTALS					\$ 11,032,372	\$ 8,354,323		\$ 135,834	25

Facility Name & ID Number Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending: 2/31/2013

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	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	408,598	21	\$	\$	16,495	\$	1
2	2	Food	Resident Days	408,598	21			16,495		2
3	3	Housekeeping	Resident Days	408,598	21			16,495		3
4	4	Laundry	Resident Days	408,598	21			16,495		4
5	5	Utilities	Resident Days	408,598	21			16,495		5
6	6	Maintenance	Resident Days	408,598	21			16,495		6
7	7	Mgmt. Allocation of Benefits	Resident Days	408,598	21			16,495		7
8	10	Nursing and Medical Records	Resident Days	408,598	21			16,495		8
9	12	Social Services	Resident Days	408,598	21			16,495		9
10	17	Administrative	Resident Days	408,598	21			16,495		10
11	19	Professional Services	Resident Days	408,598	21	1,966,927		16,495	79,404	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	408,598	21	16,972		16,495	685	12
13	21	Clerical and General Office	Resident Days	408,598	21	76,520		16,495	3,089	13
14	22	Employee Benefits & Payroll	Resident Days	408,598	21	(465)		16,495	(19)	14
15	23	Inservice Training & Education	Resident Days	408,598	21			16,495		15
16	24	Travel and Seminar	Resident Days	408,598	21			16,495		16
17	25	Other Admin. Staff Transport.	Resident Days	408,598	21			16,495		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	408,598	21			16,495		18
19	27	Mgmt. Allocation of Benefits	Resident Days	408,598	21			16,495		19
20	30	Depreciation	Resident Days	408,598	21	4,500		16,495	182	20
21	32	Interest	Resident Days	408,598	21	710,525		16,495	28,684	21
22	33	Real Estate Taxes	Resident Days	408,598	21			16,495		22
23	34	Rent-Facility and Grounds	Resident Days	408,598	21			16,495		23
24	35	Rent-Equipment & Vehicles	Resident Days	408,598	21			16,495		24
25	TOTALS					\$ 2,774,979	\$		\$ 112,025	25

Facility Name & ID Number

Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	Reporting Period Interest Expense				
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)
		YES	NO										Original	Balance		
	A. Directly Facility Related															
	Long-Term															
1	Bank of America		X	Mortgage	Varies	1/19/07	\$ 400,000	\$ 298,667	12/31/13	Varies	\$ 10,774	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 400,000	\$ 298,667			\$ 10,774	9				
	B. Non-Facility Related*															
10												10				
11											(8,899)	11				
12											4,442	12				
13											28,684	13				
14	TOTAL Non-Facility Related						\$	\$			\$ 24,227	14				
15	TOTALS (line 9+line14)						\$ 400,000	\$ 298,667			\$ 35,001	15				

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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.					
1. Real Estate Tax accrual used on 2012 report.				\$	69,540	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2012			\$	66,386	2	
3. Under or (over) accrual (line 2 minus line 1).				\$	(3,154)	3	
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	68,376	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.					(7,374)		
			Correction from County		261		
			Home Office Allocation				
TOTAL REFUND	\$	For	Tax Year.			6	
				\$			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	58,109	7	
Real Estate Tax History:							
Real Estate Tax Bill for Calendar Year:	2008	62,607	8				
	2009	64,703	9				
	2010	66,140	10				
	2011	67,519	11				
	2012	66,386	12				
Accrual based on prior year tax bill.							
				FOR BHF USE ONLY			
				13	FROM R. E. TAX STATEMENT FOR 2012	\$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sandwich Rehab & HCC 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 2012 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 2012.

(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>37,517.10</u>	\$ <u>37,517.10</u>
2. <u>19-25-252-016</u>	<u>Long-Term Care Facility</u>	\$ <u>28,869.40</u>	\$ <u>28,869.40</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>66,386.50</u></u>	\$ <u><u>66,386.50</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 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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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).

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: _____ 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:

	1	2	3	4	
A. Land.	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

Facility Name & ID Number Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	63		2005	1973	\$ 157,386	\$	25	\$ 6,295	\$ 6,295	\$ 53,508	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		Original Land Improvements	2005		10,000		15	667	667	5,669	9
10		Sidewalks	2006		8,685		15	579	579	4,246	10
11		Remodel Nurses Station	2007		11,351		15	757	757	4,920	11
12		Water Heater	2008		6,442		5	646	646	6,442	12
13		Sprinkler Head Replacement	2008		2,900		7	414	414	2,277	13
14		Sprinkler Modifications	2009		15,100		20	755	755	3,398	14
15		Water Heater	2009		4,100		5	820	820	3,690	15
16		Sewer Line Repair	2009		2,910		7	416	416	1,872	16
17		Parking Lot Sealcoat	2010		12,134		15	808	808	2,828	17
18		Water Heater	2011		5,500		7	786	786	1,965	18
19		Furnace	2012		2,955		15	198	198	297	19
20		Water Heater	2012		3,673		7	524	524	786	20
21		Parking Lot Sealcoat	2013		50,860		15	1,695	1,695	1,695	21
22		Grease Trap Installation	2013		29,500		15	983	983	983	22
23		Concrete Repair	2013		2,747		7	196	196	196	23
24		Water Heater	2013		3,731		7	267	267	267	24
25		Flooring and Carpeting-Lobby and Dining Hall	2013		15,930		15	531	531	531	25
26											26
27											27
28											28
29											29
30		Land Improvements Booked				2,055			(2,055)		30
31		Building Booked				8,326			(8,326)		31
32		Building Improvement Booked				8,213			(8,213)		32
33											33
34		2013-Home Office Allocation-Building Improvements			7,756			186	186		34
35		2013-Home Office Allocation-Land Improvements			724			46	46		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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	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)		\$ 354,384	\$ 18,594		\$ 17,569	\$ (1,025)	\$ 95,570	70

**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	\$ 24,611	\$ 1,766	\$ 2,026	\$ 260	5-10 yrs.	\$ 16,084	71
72	Current Year Purchases	4,334	461	217	(244)	10 yrs.	217	72
73	Fully Depreciated Assets	48,410					48,410	73
74	Home Office Allocation			2,620	2,620			74
75	TOTALS	\$ 77,355	\$ 2,227	\$ 4,863	\$ 2,636		\$ 64,711	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				\$	\$	\$	\$		\$	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)	\$ 443,889	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 20,821	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 22,432	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,611	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 160,281	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	\$ 17,058	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 49,964	\$ 2,007	\$ 17,058	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 Sandwich Rehab & HCC

0047555

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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: \$ 19,763 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	Facility	Ford E250 Van	\$ 571.88	\$ 6,863	17
18					18
19					19
20					20
21	TOTAL		\$ 571.88	\$ 6,863	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 Rehab & HCC

0047555

Period Beginning 1/1/2013

Period End 12/31/2013

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$ 12,366
Dishwasher	653
Laundry Equipment	-
Copier	6,263
Home Office Allocation	481
	<u>19,763</u>

Facility Name & ID Number Sandwich Rehab & HCC # 0047555 Report Period Beginning: 1/1/2013 Ending: 12/31/2013
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	\$	5,069	\$ 76,041	\$	5,069	\$ 76,041	1	
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,250	18,747		1,250	18,747	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10A(3)	hrs		6,233	93,502		6,233	93,502	4	
5	Physician Care		visits							5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy	39(2)	# of prescrpts				81,094		81,094	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			\$	12,552	\$ 188,290	\$ 81,094	12,552	\$ 269,384	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 Rehab & HCC# 0047555Report Period Beginning: 1/1/2013

Ending:

12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,812,589	\$ 1,812,589	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>39,198</u>)	800,427	800,427	3
4	Supply Inventory (priced at)	6,178	6,178	4
5	Short-Term Investments			5
6	Prepaid Insurance	28,846	28,846	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,648,040	\$ 2,648,040	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	42,969	12,150	13
14	Buildings, at Historical Cost	207,350	165,142	14
15	Leasehold Improvements, at Historical Cost	164,860	189,242	15
16	Equipment, at Historical Cost	77,355	77,355	16
17	Accumulated Depreciation (book methods)	(181,131)	(160,281)	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>Non-Care Asset-Ind. Living</u>		32,906	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 311,403	\$ 316,514	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,959,443	\$ 2,964,554	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 658,367	\$ 658,367	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	30,924	30,924	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,923	5,923	31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,376	68,376	32
33	Accrued Interest Payable	815	815	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	40,841	40,841	36
37	<u>Accrued Management Fees</u>	220,757	220,757	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,026,003	\$ 1,026,003	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	298,667	298,667	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Security Deposit</u>	23,434	23,434	43
44	<u>Intercompany Loans</u>	811,114	811,114	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,133,215	\$ 1,133,215	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,159,218	\$ 2,159,218	46
47	TOTAL EQUITY(page 18, line 24)	\$ 800,225	\$ 805,336	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,959,443	\$ 2,964,554	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 792,203	1
2	Restatements (describe):		2
3	Nursing Supplies entered after CR was completed	675	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 792,878	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	7,347	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)	\$ 7,347	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)	\$ 800,225	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	\$ 2,393,026	1
2	Discounts and Allowances for all Levels	(159,706)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,233,320	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	303,770	6
7	Oxygen	445	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 304,215	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	285	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	111,098	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,820	20
21	Other Medical Services	2,695	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 123,898	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	8,899	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 8,899	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous and Transportation Revenue	3,935	28
28a	Private Revenue - Ironwood (Expense Offset)	258,450	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 262,385	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,932,717	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	596,381	31
32	Health Care	1,242,049	32
33	General Administration	557,273	33
B. Capital Expense			
34	Ownership	115,588	34
C. Ancillary Expense			
35	Special Cost Centers	288,220	35
36	Provider Participation Fee	125,859	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,925,370	40
41	Income before Income Taxes (line 30 minus line 40)**	7,347	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 7,347	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,148,601	44
45	Private Pay - Net Inpatient Revenue	795,895	45
46	Medicare - Net Inpatient Revenue	291,297	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(2,473)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,233,320	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 **Sandwich Rehab & HCC**

0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

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	2,201	2,201	\$ 73,428	\$ 33.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,311	11,649	318,741	27.36	3
4	Licensed Practical Nurses	3,101	3,215	86,172	26.80	4
5	CNAs & Orderlies	28,053	29,417	377,590	12.84	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,749	1,843	26,562	14.41	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,717	1,717	23,972	13.96	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,939	9,237	88,356	9.57	15
16	Dishwashers					16
17	Maintenance Workers	1,951	1,972	32,128	16.29	17
18	Housekeepers	9,132	9,557	110,921	11.61	18
19	Laundry	2,268	2,420	21,980	9.08	19
20	Administrator	2,080	2,080	67,636	32.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,865	1,906	28,956	15.19	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See PG20A</u>	4,221	4,229	90,107	21.31	33
34	TOTAL (lines 1 - 33)	78,588	81,443	\$ 1,346,549 *	\$ 16.53	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	18	\$ 912	L1, C3	35
36	Medical Director	Monthly	16,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,203	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	18	\$ 20,915		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	57	1,595	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	57	\$ 1,595		53

Sandwich Rehab & HCC

0047555

Period Beginning

1/1/2013

Period End

12/31/2013

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reportin g Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,027	2,027	58,132	28.68
Transportation	201	209	2,338	11.19
Marketing	1,993	1,993	29,637	14.87
TOTAL	4,221	4,229	90,107	

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	
Jason Young	Administrator	0	\$ 46,490	Workers' Compensation Insurance	\$ 40,705	IDPH License Fee	\$ 1,990	
Tom Stephenson	Administrator	0	21,146	Unemployment Compensation Insurance	38,769	Advertising: Employee Recruitment	277	
				FICA Taxes	92,076	Health Care Worker Background Check (Indicate # of checks performed)		
				Employee Health Insurance	17,421	Patient Background Checks	57	
				Employee Meals		Miscellaneous Licenses & Permits	0	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	165	
				Employee Relations	4,655	Home Office Allocation	1,121	
				Employee Retirement	45			
				Home Office Allocation	(19)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 67,636	TOTAL (agree to Schedule V, line 22, col.8)		\$ 3,960		
B. Administrative - Other							Less: Public Relations Expense	
Description			Amount				(165)	
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 252,000				Non-allowable advertising ()	
							Yellow page advertising ()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 252,000				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		\$ 6,763				Out-of-State Travel	\$
Comcast Communications	Computer Services		925					
Gail and Rice	Accounting Services		614				In-State Travel	
Dekalb County Circuit Clerk	Filing Fees		175	N/A				
Old Second Bankcorp	Filing Fees		20				Seminar Expense	
DJ Howard and Associates	Appraisal Fees		2,000				Home Office Allocation	3
Consolidated Land Survey	Surveying Fees		2,500				Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 12,997	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 3

* Attach copy of IMRF notifications

**See instructions.

Sandwich Rehab & HCC

0047555

Period Beginning

1/1/2013

Period End

12/31/2013

Schedule 21A**XIX. SUPPORT SCHEDULE****C. Professional Services**

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		12,997
Home Office Allocation		
SmithAmundsen	Legal	407
Cole, Schotz, Meisel	Legal	224
Black, Hedin, Ballard	Legal	20
Elias, Meginnes, Riffle & Seghetti	Legal	41
Miller, Hall, and Triggs	Legal	857
Evapar	Legal	165
Ginoli & Company	Accountants	2358
E-Health Data Solutions	Computer Services	2933
Miscellaneous	Computer Services	66
Odessian LLC	Computer Services	32
CCH	Computer Services	9
Lexis-Nexis	Computer Services	4
Ipanema Solutions	Computer Services	9
Macquarie Technology Services	Computer Services	58
Advanced Answers on Demand	Computer Services	3016
TeamViewer	Computer Services	10
Stratus Networks	Computer Services	243
Kemper Technology	Computer Services	188
AT&T	Computer Services	3
Medifax	Computer Services	27
Vision Share/Ability Network	Computer Services	413
Barracuda	Computer Services	74
CIAN	Computer Services	99
Comcast	Computer Services	22
Emdeon	Computer Services	33

Marotta Gund Budd & Dzera	Other Prof Fees	73629
David Budde	Other Prof Fees	19
Pharmacy Price Mangement	Other Prof Fees	380
All Scripts	Other Prof Fees	676
Registered Agent Solutions	Other Prof Fees	32
Healthink	Other Prof Fees	210
Total (agree to Schedule V, line 19, column 8)		<u>99,254</u>

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	N/A											
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number Sandwich Rehab & HCC

0047555

Report Period Beginning:

1/1/2013

Ending:

12/31/2013

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 32,352 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. \$ 125,859
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. \$ 285
- (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. \$ 1,910
- 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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No
Attach invoices and a summary of services for all architect and appraisal fees.

Sandwich Rehabilitation & Health Care Center
004755
Period Beginning **1/1/2013**
Period End **12/31/2013**

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%
Independent Living	6,435	28.06%
Nursing Home	16,495	71.94%
	<u>22,930</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	125,093	28.06%	35,101	Census	1
Food	145,797	28.06%	40,911	Census	2
Housekeeping	123,760	28.06%	34,727	Census	3
Laundry	35,016	28.06%	9,825	Census	4
Utilities	84,565	28.06%	23,729	Census	5
Maintenance	82,150	28.06%	23,051	Census	6
Depreciation (Building)	<u>2,007</u>	100.00%	<u>2,007</u>	Beds	30
Total	<u><u>598,388</u></u>		<u><u>169,351</u></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.

