

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center

0047555 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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	9,683	4,764	2,025	16,472	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,683	4,764	2,025	16,472	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.63%

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 1,564

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

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

Facility Name & ID Number

Sandwich Rehabilitation & Health Care Cent

0047555

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 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	107,296	11,031		118,327		118,327	(30,523)	87,804		1
2	Food Purchase		128,464		128,464		128,464	(36,742)	91,722		2
3	Housekeeping	106,537	11,738		118,275		118,275	(33,484)	84,791		3
4	Laundry	21,414	8,091		29,505		29,505	(8,355)	21,150		4
5	Heat and Other Utilities			85,750	85,750		85,750	(24,056)	61,694		5
6	Maintenance	28,329	9,074	38,302	75,705		75,705	(19,784)	55,921		6
7	Other (specify):* Home Off. Ben. All.							399	399		7
8	TOTAL General Services	263,576	168,398	124,052	556,026		556,026	(152,545)	403,481		8
	B. Health Care and Programs										
9	Medical Director			14,000	14,000		14,000		14,000		9
10	Nursing and Medical Records	820,475	86,526	49,311	956,312		956,312	29	956,341		10
10a	Therapy		286	153,231	153,517		153,517		153,517		10a
11	Activities	27,856	50	80	27,986		27,986	(1,702)	26,284		11
12	Social Services	2,853	54		2,907		2,907		2,907		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.										15
16	TOTAL Health Care and Programs	851,184	86,916	216,622	1,154,722		1,154,722	(1,673)	1,153,049		16
	C. General Administration										
17	Administrative			206,000	206,000		206,000	(155,021)	50,979		17
18	Directors Fees										18
19	Professional Services			2,557	2,557		2,557	70,103	72,660		19
20	Dues, Fees, Subscriptions & Promotions			5,436	5,436		5,436	102	5,538		20
21	Clerical & General Office Expenses	30,928	3,045	19,219	53,192		53,192	34,609	87,801		21
22	Employee Benefits & Payroll Taxes			154,973	154,973		154,973		154,973		22
23	Inservice Training & Education							57	57		23
24	Travel and Seminar							6	6		24
25	Other Admin. Staff Transportation			3,771	3,771		3,771	3,924	7,695		25
26	Insurance-Prop.Liab.Malpractice			25,242	25,242		25,242	641	25,883		26
27	Other (specify):* Home Off. Ben. All.							8,007	8,007		27
28	TOTAL General Administration	30,928	3,045	417,198	451,171		451,171	(37,572)	413,599		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,145,688	258,359	757,872	2,161,919		2,161,919	(191,790)	1,970,129		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.

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			23,105	23,105		23,105	(3,536)	19,569			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,075	31,075		31,075	46,048	77,123			32
33	Real Estate Taxes			68,899	68,899		68,899	424	69,323			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,047	17,047		17,047	468	17,515			35
36	Other (specify):*											36
37	TOTAL Ownership			140,126	140,126		140,126	43,404	183,530			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		78,765		78,765		78,765		78,765			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			191,994	191,994		191,994		191,994			42
43	Other (specify):* Non-allowable Costs	23,962	219	29,085	53,266		53,266	(53,266)				43
44	TOTAL Special Cost Centers	23,962	78,984	221,079	324,025		324,025	(53,266)	270,759			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,169,650	337,343	1,119,077	2,626,070		2,626,070	(201,652)	2,424,418			45

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

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center

0047555

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(449)	2		4
5	Telephone, TV & Radio in Resident Rooms	(6,611)	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	(6,005)	30		9
10	Interest and Other Investment Income	(174)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(29)	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	(10,155)	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	(79)	43		24
25	Fund Raising, Advertising and Promotional	(24,990)	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	(171,524)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (220,016)		\$	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)	18,364	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 18,364		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (201,652)		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 Rehabilitation & Health Care CenterID# 0047555Report Period Beginning: 1/1/2012Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Offset Chamber of Commerce Dues	\$ (165)	20	1
2	Offset Miscellaneous Office Supplies Revenue	(249)	21	2
3	Disallowed Special Events	(142)	43	3
4	Independent Living depreciation offset	(484)	30	4
5	Independent Living - Dietary	(33,522)	1	5
6	Independent Living - Food	(36,394)	2	6
7	Independent Living - Housekeeping	(33,507)	3	7
8	Independent Living - Laundry	(8,359)	4	8
9	Independent Living - Maintenance	(21,447)	6	9
10	Independent Living - Utilities	(24,293)	5	10
11	Labs-Part A	(8,564)	43	11
12	X-Rays-Part A	(2,696)	43	12
13	Offset Transportation Revenue	(1,702)	21	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		(171,524)	49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

	Operating Expenses	PAGES	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	(33,522)	2,999	0	0	0	0	0	0	0	0	0	(30,523)	1
2	Food Purchase	(36,843)	101	0	0	0	0	0	0	0	0	0	(36,742)	2
3	Housekeeping	(33,507)	23	0	0	0	0	0	0	0	0	0	(33,484)	3
4	Laundry	(8,359)	4	0	0	0	0	0	0	0	0	0	(8,355)	4
5	Heat and Other Utilities	(24,293)	237	0	0	0	0	0	0	0	0	0	(24,056)	5
6	Maintenance	(21,447)	1,663	0	0	0	0	0	0	0	0	0	(19,784)	6
7	Other (specify):*	0	399	0	0	0	0	0	0	0	0	0	399	7
8	TOTAL General Services	(157,971)	5,426	0	0	0	0	0	0	0	0	0	(152,545)	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	29	0	0	0	0	0	0	0	0	0	29	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	0	29	0	0	0	0	0	0	0	0	0	29	16
	C. General Administration													
17	Administrative	0	(155,021)	0	0	0	0	0	0	0	0	0	(155,021)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,198	0	53,905	0	0	0	0	0	0	0	70,103	19
20	Fees, Subscriptions & Promotions	(165)	0	231	36	0	0	0	0	0	0	0	102	20
21	Clerical & General Office Expenses	(1,951)	0	33,943	915	0	0	0	0	0	0	0	32,907	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	57	0	0	0	0	0	0	0	0	57	23
24	Travel and Seminar	0	0	6	0	0	0	0	0	0	0	0	6	24
25	Other Admin. Staff Transportation	0	0	3,889	35	0	0	0	0	0	0	0	3,924	25
26	Insurance-Prop.Liab.Malpractice	0	0	641	0	0	0	0	0	0	0	0	641	26
27	Other (specify):*	0	0	8,007	0	0	0	0	0	0	0	0	8,007	27
28	TOTAL General Administration	(2,116)	(138,823)	46,774	54,891	0	0	0	0	0	0	0	(39,274)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(160,087)	(133,368)	46,774	54,891	0	0	0	0	0	0	0	(191,790)	29

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/2012 Ending:

12/31/2012

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

	Capital Expense	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	(6,489)	0	2,881	72	0	0	0	0	0	0	0	(3,536)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(174)	0	5,728	40,494	0	0	0	0	0	0	0	46,048	32
33	Real Estate Taxes	0	0	424	0	0	0	0	0	0	0	0	424	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	422	46	0	0	0	0	0	0	0	468	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(6,663)	0	9,455	40,612	0	0	0	0	0	0	0	43,404	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):*	(53,266)	0	0	0	0	0	0	0	0	0	0	(53,266)	43
44	TOTAL Special Cost Centers	(53,266)	0	0	0	0	0	0	0	0	0	0	(53,266)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(220,016)	(133,368)	56,229	95,503	0	0	0	0	0	0	0	(201,652)	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%	\$ 2,999	\$ 2,999	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	101	101	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	23	23	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	4	4	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	237	237	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,663	1,663	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	399	399	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	29	29	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	206,000	Petersen Health Care, Inc.	100.00%	50,979	(155,021)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	16,198	16,198	12
13	V							13
14	Total		\$ 206,000			\$ 72,632	\$ * (133,368)	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%	\$ 231	\$	231	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	33,943		33,943	16
17	V	23 Inservice Training & Education		Petersen Health Care, Inc.	100.00%	57		57	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	6		6	18
19	V	25 Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,889		3,889	19
20	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	641		641	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	8,007		8,007	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,881		2,881	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	5,728		5,728	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	424		424	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%	422		422	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		\$			\$ 56,229	\$ *	56,229	39

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

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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%	53,905	53,905	25	
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Operations, LLC	100.00%	36	36	26	
27	V	21 Clerical and General Office		Petersen Health Operations, LLC	100.00%	915	915	27	
28	V	22 Employee Benefits & Payroll		Petersen Health Operations, LLC	100.00%	0		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%	35	35	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%	72	72	34	
35	V	32 Interest		Petersen Health Operations, LLC	100.00%	40,494	40,494	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%	46	46	38	
39	Total		\$			\$ 95,503	\$ *	95,503	39

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

Facility Name & ID Number

Sandwich Rehabilitation & Health Care Center

0047555

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care 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 Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Sandwich Rehabilitation & Health Care Center

0047555

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Sandwich Rehabilitation & Health Care Cer # 0047555 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1 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 Rehabilitation & Health Care Center

0047555

Report Period Beginning:

1/1/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	1,569,393	74	\$ 285,707	\$ 284,214	16,472	\$ 2,999	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	16,472	101	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	16,472	23	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	16,472	4	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	16,472	237	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	16,472	1,663	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	16,472	399	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	16,472	29	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	16,472	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	16,472	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	16,472	50,979	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	16,472	16,198	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	16,472	231	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	16,472	33,943	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	16,472	57	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	16,472	6	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	16,472	3,889	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	16,472	641	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	16,472	8,007	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	16,472	2,881	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	16,472	5,728	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	16,472	424	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	16,472	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	16,472	422	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 128,861	25

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center

0047555

Report Period Beginning:

1/1/2012

Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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	404,785	21		16,472		1
2	2	Food	Resident Days	404,785	21		16,472		2
3	3	Housekeeping	Resident Days	404,785	21		16,472		3
4	4	Laundry	Resident Days	404,785	21		16,472		4
5	5	Utilities	Resident Days	404,785	21		16,472		5
6	6	Maintenance	Resident Days	404,785	21		16,472		6
7	7	Mgmt. Allocation of Benefits	Resident Days	404,785	21		16,472		7
8	10	Nursing and Medical Records	Resident Days	404,785	21		16,472		8
9	12	Social Services	Resident Days	404,785	21		16,472		9
10	17	Administrative	Resident Days	404,785	21		16,472		10
11	19	Professional Services	Resident Days	404,785	21	1,324,676	16,472	53,905	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	404,785	21	876	16,472	36	12
13	21	Clerical and General Office	Resident Days	404,785	21	22,478	16,472	915	13
14	22	Employee Benefits & Payroll	Resident Days	404,785	21		16,472		14
15	23	Inservice Training & Education	Resident Days	404,785	21		16,472		15
16	24	Travel and Seminar	Resident Days	404,785	21		16,472		16
17	25	Other Admin. Staff Transport.	Resident Days	404,785	21	849	16,472	35	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	404,785	21		16,472		18
19	27	Mgmt. Allocation of Benefits	Resident Days	404,785	21		16,472		19
20	30	Depreciation	Resident Days	404,785	21	1,761	16,472	72	20
21	32	Interest	Resident Days	404,785	21	995,096	16,472	40,494	21
22	33	Real Estate Taxes	Resident Days	404,785	21		16,472		22
23	34	Rent-Facility and Grounds	Resident Days	404,785	21		16,472		23
24	35	Rent-Equipment & Vehicles	Resident Days	404,785	21	1,130	16,472	46	24
25	TOTALS					\$ 2,346,866	\$	\$ 95,503	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	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	Bank of America		X	Mortgage	Varies	1/19/07	\$ 400,000	\$ 374,182	12/31/13	Varies	\$ 31,075	1				
2												2				
3												3				
4												4				
5												5				
Working Capital																
6												6				
7												7				
8												8				
9	TOTAL Facility Related						\$ 400,000	\$ 374,182			\$ 31,075	9				
B. Non-Facility Related*																
10												10				
11											(174)	11				
12											5,728	12				
13											40,494	13				
14	TOTAL Non-Facility Related						\$	\$			\$ 46,048	14				
15	TOTALS (line 9+line14)						\$ 400,000	\$ 374,182			\$ 77,123	15				

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

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

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

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 2011 report.			\$	68,160	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2011		\$	67,519	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(641)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	69,540	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND	\$	For	Tax Year.	(Attach a copy of the real estate tax appeal board's decision.)	
				424	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	69,323	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2007	60,487			8
	2008	62,607			9
	2009	64,703			10
	2010	66,140			11
	2011	67,519			12
Accrual based on prior year tax bill.					
FOR BHF USE ONLY					
	13	FROM R. E. TAX STATEMENT FOR 2011	\$		13
	14	PLUS APPEAL COST FROM LINE 5	\$		14
	15	LESS REFUND FROM LINE 6	\$		15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)	(B)	(C)	(D)
<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>36,631.04</u>	\$ <u>36,631.04</u>
2. <u>19-25-252-016</u>	<u>Long-Term Care Facility</u>	\$ <u>30,888.38</u>	\$ <u>30,888.38</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>67,519.42</u></u>	\$ <u><u>67,519.42</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

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

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

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

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	\$ 47,213
5									
6									
7									
8									
Improvement Type**									
9	Original Land Improvements	2005		10,000		15	667	667	5,002
10	Sidewalks	2006		8,685		15	579	579	3,667
11	Remodel Nurses Station	2007		11,351		15	757	757	4,163
12	Water Heater	2008		6,442		5	1,288	1,288	5,796
13	Sprinkler Head Replacement	2008		2,900		7	414	414	1,863
14	Sprinkler Modifications	2009		15,100		20	755	755	2,643
15	Water Heater	2009		4,100		5	820	820	2,870
16	Sewer Line Repair	2009		2,910		7	416	416	1,456
17	Parking Lot Sealcoat	2010		12,134		15	808	808	2,020
18	Water Heater	2011		5,500		7	786	786	1,179
19	Furnace	2012		2,955		15	99	99	99
20	Water Heater	2012		3,673		7	262	262	262
21									
22									
23									
24									
25									
26									
27									
28									
29									
30	Land Improvements Booked				2,055			(2,055)	
31	Building Booked				8,326			(8,326)	
32	Building Improvement Booked				5,545			(5,545)	
33									
34	2012-Home Office Allocation-Land Improvements			719			46	46	
35	2012-Home Office Allocation-Building Improvements			7,704			185	185	
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)		\$ 251,559	\$ 15,926		\$ 14,177	\$ (1,749)	\$ 78,233	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	\$ 21,901	\$ 6,889	\$ 2,535	\$ (4,354)	5-10 yrs.	\$ 13,923	71
72	Current Year Purchases	2,709	290	135	(155)	10 yrs.	135	72
73	Fully Depreciated Assets	48,410					48,410	73
74	Home Office Allocation			2,722	2,722			74
75	TOTALS	\$ 73,020	\$ 7,179	\$ 5,392	\$ (1,787)		\$ 62,468	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	N/A									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)	\$ 336,729	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 23,105	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 19,569	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,536)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 140,701	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	\$ 15,051	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 49,964	\$ 2,007	\$ 15,051	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								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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

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: \$ 10,652 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 Rehabilitation & Health Care Center

004755

Period Beginning

1/1/2012

Period End

12/31/2012

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	4,403
Dishwasher		731
Laundry Equipment		-
Copier		5,050
Home Office Allocation		468
		<u>10,652</u>

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0047555 Report Period Beginning: 1/1/2012 Ending: 12/31/2012
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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. 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 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	4,399	\$ 65,984	\$	4,399	\$ 65,984	1
2	Licensed Speech and Language Development Therapist	10A(2), 10A(3)	hrs		843	12,650	286	843	12,936	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		4,973	74,597		4,973	74,597	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				78,765		78,765	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	10,215	\$ 153,231	\$ 79,051	10,215	\$ 232,282	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# 0047555Report Period Beginning: 1/1/2012

Ending:

12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012

(last day of reporting year)

This report must be completed even if 805,184

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,133,256	\$ 1,133,256	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>25,000</u>)	591,437	591,437	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,271	25,271	6
7	Other Prepaid Expenses	6,178	6,178	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Security Deposit</u>	3,418	3,418	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,759,560	\$ 1,759,560	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	250,319	165,090	14
15	Leasehold Improvements, at Historical Cost	54,931	86,469	15
16	Equipment, at Historical Cost	73,021	73,020	16
17	Accumulated Depreciation (book methods)	(160,311)	(140,701)	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>		34,913	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 217,960	\$ 230,941	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,977,520	\$ 1,990,501	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 525,944	\$ 525,944	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,116	22,116	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,371	14,371	31
32	Accrued Real Estate Taxes(Sch.IX-B)	69,540	69,540	32
33	Accrued Interest Payable	1,033	1,033	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	18,421	18,421	36
37	<u>Accrued Management Fee</u>	138,107	138,107	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 789,532	\$ 789,532	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	374,182	374,182	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Security Deposit</u>	21,603	21,603	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 395,785	\$ 395,785	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,185,317	\$ 1,185,317	46
47	TOTAL EQUITY(page 18, line 24)	\$ 792,203	\$ 805,184	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,977,520	\$ 1,990,501	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 481,276	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 481,276	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	310,927	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)	\$ 310,927	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)	\$ 792,203	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	\$ 2,470,114	1
2	Discounts and Allowances for all Levels	(161,753)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,308,361	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	255,370	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 255,370	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	449	14
15	Telephone, Television and Radio	(15)	15
16	Rental of Facility Space		16
17	Sale of Drugs	114,727	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	14,662	20
21	Other Medical Services	2,702	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 132,525	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income****	174	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 174	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous and Transportation Revenue	1,951	28
28a	Private Revenue - Ironwood (Expense Offset)	238,616	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 240,567	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,936,997	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	556,026	31
32	Health Care	1,154,722	32
33	General Administration	451,171	33
B. Capital Expense			
34	Ownership	140,126	34
C. Ancillary Expense			
35	Special Cost Centers	132,031	35
36	Provider Participation Fee	191,994	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,626,070	40
41	Income before Income Taxes (line 30 minus line 40)**	310,927	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 310,927	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,199,594	44
45	Private Pay - Net Inpatient Revenue	654,620	45
46	Medicare - Net Inpatient Revenue	457,214	46
47	Other-(specify) <u>Charity Therapy Allowance</u>	(2,362)	47
48	Other-(specify) <u>Insurance Contractual Allowance</u>	(705)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 2,308,361	49

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

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

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

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

Facility Name & ID Number **Sandwich Rehabilitation & Health Care Center**

0047555

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,080	2,080	\$ 69,308	\$ 33.32	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,950	8,048	209,485	26.03	3
4	Licensed Practical Nurses	5,442	5,765	141,104	24.48	4
5	CNAs & Orderlies	27,347	28,371	345,279	12.17	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,710	1,795	23,315	12.99	9
10	Activity Assistants	60	60	595	9.92	10
11	Social Service Workers	238	238	2,853	11.99	11
12	Dietician					12
13	Food Service Supervisor	2,100	2,124	29,823	14.04	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,711	8,846	77,473	8.76	15
16	Dishwashers					16
17	Maintenance Workers	1,906	1,909	28,329	14.84	17
18	Housekeepers	9,284	9,883	106,537	10.78	18
19	Laundry	2,419	2,526	21,414	8.48	19
20	Administrator	2,080	2,080	50,979	24.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,906	2,159	30,928	14.33	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>	4,162	4,162	83,207	19.99	33
34	TOTAL (lines 1 - 33)	77,395	80,046	\$ 1,220,629 *	\$ 15.25	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	\$		35
36	Medical Director	Monthly 14,000	L9, C3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 2,678	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)	\$ 16,678		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	8 \$ 240	L10, C3	50
51	Licensed Practical Nurses	1,283 46,393	L10, C3	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	1,291 \$ 46,633		53

Sandwich Rehabilitation & Health Care Center

0047555

Period Beginning 1/1/2012

Period End 12/31/2012

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,080	2,080	55,299	26.59
Transportation	363	363	3,946	10.87
Marketing	1,719	1,719	23,962	13.94
TOTAL	4,162	4,162	83,207	

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	
Kathleen Heuertz	Administrator	0	\$ 15,021	Workers' Compensation Insurance	\$ 31,816	IDPH License Fee	\$ 3,980	
Jason Young	Administrator	0	35,958	Unemployment Compensation Insurance	30,099	Advertising: Employee Recruitment		
				FICA Taxes	86,746	Health Care Worker Background Check		
				Employee Health Insurance	5,580	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks	67	
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	623	
				Employee Relations	395	Miscellaneous Dues & Subscriptions	165	
				Employee Retirement	337	Home Office Allocation	267	
TOTAL (agree to Schedule V, line 17, col. 1)								
(List each licensed administrator separately.)			\$ 50,979					
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 206,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 206,000				Seminar Expense	
(Attach a copy of any management service agreement)							Home Office Allocation	6
C. Professional Services				TOTAL			Entertainment Expense	
Vendor/Payee	Type	Amount					(agree to Sch. V,	
E-Health Data Solutions	Computer Services	\$ 1,460					line 24, col. 8)	
Comcast Communications	Computer Services	1,293						
DeKalb County Circuit Clerk	Reversal of 2011 Invoices	(106)						
Richland County Recorder	Reversal of 2011 Invoices	(90)						
TOTAL (agree to Schedule V, line 19, column 3)				\$			TOTAL	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 2,557				\$ 6	

* Attach copy of IMRF notifications

**See instructions.

Sandwich Rehabilitation & Health Care Center

004755

Period Beginning 1/1/2012

Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		2,557

Home Office Allocation

Sorling Northrup	Legal	51
Ginoli & Company	Accountants	1,843
Miscellaneous	Computer Services	44
Nebo Systems	Computer Services	1
Advanced Answers on Demand	Computer Services	2503
Access 2 Go	Computer Services	105
Stratus Networks	Computer Services	104
Kemper Technology	Computer Services	171
CCH	Computer Services	9
Medifax	Computer Services	20
Vision Share/Ability Network	Computer Services	191
Barracuda	Computer Services	7
CIAN	Computer Services	52
Comcast	Computer Services	16
Postini	Computer Services	162
Optimizer Systems	Other Prof Fees	25
Marotta Gund Budd & Dzera	Other Prof Fees	64196
David Budde	Other Prof Fees	10
Courtney Bourban	Other Prof Fees	143
All Scripts	Other Prof Fees	437
Heritage Enterprises	Other Prof Fees	10
Miscellaneous Vendors	Other Prof Fees	3

Total (agree to Schedule V, line 19, column 8)	<u><u>72,660</u></u>
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Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE

Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
		100%	-
Home Office Allocation			
Heyl, Royster, Voelker, and Allen			-
GoffWilson			-
Jackson Lewis			-
Peter Gartelos			-
Miscellaneous Vendors			-
Total Legal Fees			<u><u>-</u></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 Rehabilitation & Health Care Center# 0047555

Report Period Beginning:

1/1/2012

Ending:

12/31/2012**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. \$ 30,332 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. \$ 191,994
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. \$ 449
- (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. \$ 1,702
- 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 1/1/2011
 Period End 12/31/2011

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%	Beds	%
Independent Living	6,511	28.33%	20	24.10%
Nursing Home	16,472	71.67%	63	75.90%
	<u>22,983</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	118,327	28.33%	33,522	Census	1
Food	128,464	28.33%	36,394	Census	2
Housekeeping	118,275	28.33%	33,507	Census	3
Laundry	29,505	28.33%	8,359	Census	4
Utilities	85,750	28.33%	24,293	Census	5
Maintenance	75,705	28.33%	21,447	Census	6
Depreciation (Building)	<u>2,007</u>	24.10%	<u>484</u>	Beds	30
Total	<u><u>558,033</u></u>		<u><u>158,006</u></u>		

Building Cost Offset:

P12 Building Cost 24.10% (7) 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 costs have been offset on P5A.