

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center

0053546 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	9,203	1,586	996	11,785	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,203	1,586	996	11,785	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 51.25%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve 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 32 and days of care provided 996

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2018 Fiscal Year: 12/31/2018

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

Facility Name & ID Number Sandwich Rehabilitation & Health Care Cent # 0053546 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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	133,752	13,437	549	147,738		147,738	(40,111)	107,627		1
2	Food Purchase		118,259		118,259		118,259	(34,875)	83,384		2
3	Housekeeping	104,126	13,342		117,468		117,468	(34,123)	83,345		3
4	Laundry	14,698	11,719		26,417		26,417	(7,369)	19,048		4
5	Heat and Other Utilities			95,038	95,038		95,038	(27,498)	67,540		5
6	Maintenance	28,806	13,354	41,194	83,354		83,354	(23,123)	60,231		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	TOTAL General Services	281,382	170,111	136,781	588,274		588,274	(167,099)	421,175		8
	B. Health Care and Programs										
9	Medical Director			16,800	16,800		16,800		16,800		9
10	Nursing and Medical Records	746,943	70,680	27,103	844,726		844,726	2,692	847,418		10
10a	Therapy			100,298	100,298		100,298		100,298		10a
11	Activities	46,328	106	559	46,993		46,993	(4,709)	42,284		11
12	Social Services	8,234	4		8,238		8,238		8,238		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	TOTAL Health Care and Programs	801,505	70,790	144,760	1,017,055		1,017,055	(2,017)	1,015,038		16
	C. General Administration										
17	Administrative			202,300	202,300		202,300	(128,572)	73,728		17
18	Directors Fees										18
19	Professional Services			(5,605)	(5,605)		(5,605)	14,790	9,185		19
20	Dues, Fees, Subscriptions & Promotions			4,998	4,998		4,998	2,729	7,727		20
21	Clerical & General Office Expenses	33,115	2,388	11,959	47,462		47,462	29,332	76,794		21
22	Employee Benefits & Payroll Taxes			123,628	123,628		123,628	12,695	136,323		22
23	Inservice Training & Education							72	72		23
24	Travel and Seminar							1	1		24
25	Other Admin. Staff Transportation			6,318	6,318		6,318	2,179	8,497		25
26	Insurance-Prop.Liab.Malpractice			25,877	25,877		25,877	546	26,423		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	TOTAL General Administration	33,115	2,388	369,475	404,978		404,978	(66,228)	338,750		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,116,002	243,289	651,016	2,010,307		2,010,307	(235,344)	1,774,963		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Sandwich Rehabilitation & Health Care Center

#0053546

Report Period Beginning:

1/1/2018

Ending:

12/31/2018

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			34,486	34,486		34,486	(863)	33,623			30
31	Amortization of Pre-Op. & Org.							4,216	4,216			31
32	Interest			321,047	321,047		321,047	22,733	343,780			32
33	Real Estate Taxes			61,811	61,811		61,811	216	62,027			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			19,598	19,598		19,598	629	20,227			35
36	Other (specify):*											36
37	TOTAL Ownership			436,942	436,942		436,942	26,931	463,873			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		19,648		19,648		19,648		19,648			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			99,181	99,181		99,181		99,181			42
43	Other (specify):* Miscellaneous	17,355	199	109,341	126,895		126,895	(126,895)				43
44	TOTAL Special Cost Centers	17,355	19,847	208,522	245,724		245,724	(126,895)	118,829			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,133,357	263,136	1,296,480	2,692,973		2,692,973	(335,308)	2,357,665			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	(504)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,022)	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	(5,385)	30		9
10	Interest and Other Investment Income	(1,540)	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	(17,909)	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	(75,000)	43		24
25	Fund Raising, Advertising and Promotional	(124)	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	(206,238)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (315,751)		\$	30

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)	(19,557)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (19,557)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (335,308)		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.			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44					44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

BHF USE ONLY							
48		49		50		51	

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (5,494)	43	1
2	X-Rays-Part A	(1,015)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,970)	10	3
4	Offset Transportation Revenue	(4,709)	11	4
5	Offset Marketing Salaries	(17,355)	43	5
6	Disallowed Special Events	(947)	43	6
7	Disallowed Chamber of Commerce Dues	(175)	20	7
8	Independent Living Dietary Cost Offset	(42,973)	1	8
9	Independent Living Food Cost Offset	(34,398)	2	9
10	Independent Living Housekeeping Cost Offset	(34,168)	3	10
11	Independent Living Laundry Cost Offset	(7,684)	4	11
12	Independent Living Utilities Cost Offset	(27,644)	5	12
13	Independent Living Maintenance Cost Offset	(24,245)	6	13
14	Independent Living Depreciation Cost Offset	(2,424)	30	14
15	Offset Miscellaneous Office Supplies Revenue	(37)	21	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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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	(206,238)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,862	\$ 2,862	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	27	27	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	45	45	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	146	146	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,122	1,122	5
6	V	7 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9 Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10 Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	1,981	1,981	8
9	V	10A Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17 Administrative	118,300	Petersen Health Care Management, Inc.	100.00%	73,728	(44,572)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	8,663	8,663	12
13	V							13
14	Total		\$ 118,300			\$ 88,574	\$ * (29,726)	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 <u>Dues, Fees, Subs & Promotions</u>	\$	<u>Petersen Health Care Management, Inc.</u>	100.00%	\$ 2,123	\$	2,123	15
16	V	21 <u>Clerical and General Office</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	29,369		29,369	16
17	V	22 <u>Employee Benefits and Payroll Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	12,335		12,335	17
18	V	23 <u>Inservice Training & Education</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	72		72	18
19	V	24 <u>Travel and Seminar</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1		1	19
20	V	25 <u>Other Admin. Staff Transport.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	2,179		2,179	20
21	V	26 <u>Insurance-Prop./Liab./Malprac.</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	546		546	21
22	V	30 <u>Depreciation</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	6,946		6,946	22
23	V	31 <u>Amortization</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	63		63	23
24	V	32 <u>Interest</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	1,827		1,827	24
25	V	33 <u>Real Estate Taxes</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	216		216	25
26	V	35 <u>Rent-Equipment & Vehicles</u>		<u>Petersen Health Care Management, Inc.</u>	100.00%	629		629	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		\$			\$ 56,306	\$ *	56,306	39

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

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center# 0053546Report Period Beginning: 1/1/2018Ending: 12/31/2018

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Petersen Health Business, LLC	100.00%	\$ 0	\$
16	V	2 Food		Petersen Health Business, LLC	100.00%	0	
17	V	3 Housekeeping		Petersen Health Business, LLC	100.00%	0	
18	V	4 Laundry		Petersen Health Business, LLC	100.00%	315	315
19	V	5 Utilities		Petersen Health Business, LLC	100.00%	0	
20	V	6 Maintenance		Petersen Health Business, LLC	100.00%	0	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0	
22	V	10 Nursing and Medical Records		Petersen Health Business, LLC	100.00%	3,681	3,681
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%	0	
24	V	17 Administrative	84,000	Petersen Health Business, LLC	100.00%	0	(84,000)
25	V	19 Professional Services		Petersen Health Business, LLC	100.00%	6,127	6,127
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%	781	781
27	V	21 Clerical and General Office		Petersen Health Business, LLC	100.00%	0	
28	V	22 Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%	360	360
29	V	23 Inservice Training & Education		Petersen Health Business, LLC	100.00%	0	
30	V	24 Travel and Seminar		Petersen Health Business, LLC	100.00%	0	
31	V	25 Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%	0	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%	0	
33	V	30 Depreciation		Petersen Health Business, LLC	100.00%	0	
34	V	31 Amortization		Petersen Health Business, LLC	100.00%	4,153	4,153
35	V	32 Interest		Petersen Health Business, LLC	100.00%	22,446	22,446
36	V	33 Real Estate Taxes		Petersen Health Business, LLC	100.00%	0	
37	V	34 Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%	0	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%	0	
39	Total		\$ 84,000			\$ 37,863	\$ * (46,137)

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

Facility Name & ID Number

Sandwich Rehabilitation & Health Care Center

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Report Period Beginning:

1/1/2018

Ending: 12/31/2018

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 I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	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	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	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

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0053546

Report Period Beginning:

1/1/2018

Ending:

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VII. RELATED PARTIES

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

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

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Bloomington Rehabilitation & Health Care Center

0047415

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				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 Cen # 0053546 Report Period Beginning: 1/1/2018 Ending: 12/31/2018

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 # 0053546 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,411,762	75	\$ 342,871	\$ 393,211	11,785	\$ 2,862	1
2	2	Food	Resident Days	1,411,762	75	3,216	0	11,785	27	2
3	3	Housekeeping	Resident Days	1,411,762	75	5,441	2,652	11,785	45	3
4	5	Utilities	Resident Days	1,411,762	75	17,524	0	11,785	146	4
5	6	Maintenance	Resident Days	1,411,762	75	134,460	148,272	11,785	1,122	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	11,785	0	6
7	9	Medical Director	Resident Days	1,411,762	75	0	0	11,785	0	7
8	10	Nursing and Medical Records	Resident Days	1,411,762	75	237,275	1,454,984	11,785	1,981	8
9	10A	Therapy	Resident Days	1,411,762	75	0	0	11,785	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,411,762	75	0	0	11,785	0	10
11	17	Administrative	Resident Days	1,411,762	75	4,940,583	5,658,897	11,785	73,728	11
12	19	Professional Services	Resident Days	1,411,762	75	1,037,806	0	11,785	8,663	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,411,762	75	254,355	0	11,785	2,123	13
14	21	Clerical and General Office	Resident Days	1,411,762	75	3,518,216	3,764,024	11,785	29,369	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,411,762	75	1,477,639	0	11,785	12,335	15
16	23	Inservice Training & Education	Resident Days	1,411,762	75	8,601	0	11,785	72	16
17	24	Travel and Seminar	Resident Days	1,411,762	75	174	0	11,785	1	17
18	25	Other Admin. Staff Transport.	Resident Days	1,411,762	75	261,018	0	11,785	2,179	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,411,762	75	65,437	0	11,785	546	19
20	30	Depreciation	Resident Days	1,411,762	75	832,087	0	11,785	6,946	20
21	31	Amortization	Resident Days	1,411,762	75	7,528	0	11,785	63	21
22	32	Interest	Resident Days	1,411,762	75	218,814	0	11,785	1,827	22
23	33	Real Estate Taxes	Resident Days	1,411,762	75	25,901	0	11,785	216	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,411,762	75	75,380	0	11,785	629	24
25	TOTALS					\$ 13,464,326	\$ 11,422,040		\$ 144,880	25

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center # 0053546 Report Period Beginning: 1/1/2018 Ending: 2/31/2018

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	150,333	9	\$	\$ 11,785	\$	1
2	2	Food	Resident Days	150,333	9		11,785		2
3	3	Housekeeping	Resident Days	150,333	9		11,785		3
4	4	Laundry	Resident Days	150,333	9	4,021	11,785	315	4
5	5	Utilities	Resident Days	150,333	9		11,785		5
6	6	Maintenance	Resident Days	150,333	9		11,785		6
7	7	Mgmt. Allocation of Benefits	Resident Days	150,333	9		11,785		7
8	10	Nursing and Medical Records	Resident Days	150,333	9	46,960	11,785	3,681	8
9	15	Mgmt. Allocation of Benefits	Resident Days	150,333	9		11,785		9
10	17	Administrative	Resident Days	150,333	9		11,785		10
11	19	Professional Services	Resident Days	150,333	9	78,162	11,785	6,127	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	150,333	9	9,959	11,785	781	12
13	21	Clerical and General Office	Resident Days	150,333	9		11,785		13
14	22	Employee Benefits & Payroll	Resident Days	150,333	9	4,586	11,785	360	14
15	23	Inservice Training & Education	Resident Days	150,333	9		11,785		15
16	24	Travel and Seminar	Resident Days	150,333	9		11,785		16
17	25	Other Admin. Staff Transport.	Resident Days	150,333	9		11,785		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	150,333	9		11,785		18
19	30	Depreciation	Resident Days	150,333	9		11,785		19
20	31	Amortization	Resident Days	150,333	9	52,973	11,785	4,153	20
21	32	Interest	Resident Days	150,333	9	286,324	11,785	22,446	21
22	33	Real Estate Taxes	Resident Days	150,333	9		11,785		22
23	34	Rent-Facility and Grounds	Resident Days	150,333	9		11,785		23
24	35	Rent-Equipment & Vehicles	Resident Days	150,333	9		11,785		24
25	TOTALS					\$ 482,985	\$	\$ 37,863	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		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
A. Directly Facility Related																		
Long-Term																		
1	Bank Leumi		X	Mortgage	Varies	3/27/15	\$ 2,690,719	\$ 2,521,597	12/31/2024	Varies	\$ 321,047	1						
2												2						
3												3						
4												4						
5												5						
Working Capital																		
6												6						
7												7						
8												8						
9	TOTAL Facility Related						\$ 2,690,719	\$ 2,521,597			\$ 321,047	9						
B. Non-Facility Related*																		
10									Interest Income Offset		(1,540)	10						
11									Home Office Allocation-PHB		22,446	11						
12									Home Office Allocation-PHCM		1,827	12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$ 22,733	14						
15	TOTALS (line 9+line14)						\$ 2,690,719	\$ 2,521,597			\$ 343,780	15						

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sandwich Rehabilitation & Health Care Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0053546

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

TELEPHONE (309)689-5850 FAX #: (309)691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2017 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 2017.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>19-25-252-015</u>	<u>Long-Term Care Facility</u>	\$ <u>38,442.74</u>	\$ <u>38,442.74</u>
2. <u>19-25-252-016</u>	<u>Long-Term Care Facility</u>	\$ <u>23,350.36</u>	\$ <u>23,350.36</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>61,793.10</u></u>	\$ <u><u>61,793.10</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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Independent Living Facility

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: 188,175 2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 4,216 4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

B. Building 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	\$ 226,000	\$	25	\$ 6,962	\$ 6,962	\$ 93,987	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Sidewalks		2006	8,685		15	579	579	7,141	9
10	Remodel Nurses Station		2007	11,351		15	757	757	7,948	10
11	Sprinkler Head Replacement		2008	2,900		7			2,900	11
12	Sprinkler Modifications		2009	15,100		20	755	755	6,418	12
13	Water Heater		2009	4,100		5			4,100	13
14	Sewer Line Repair		2009	2,910		7			2,910	14
15	Furnace		2012	2,955		15	198	198	1,089	15
16	Water Heater-100 Gallon		2012	3,673		7	524	524	2,882	16
17	Parking Lot Sealcoat		2013	50,860		15	3,390	3,390	18,645	17
18	Grease Trap Installation		2013	29,500		15	1,966	1,966	10,813	18
19	Concrete Repair		2013	2,747		7	392	392	2,156	19
20	Flooring and Carpeting-Lobby and Dining Hall		2013	15,930		15	1,062	1,062	4,779	20
21	A/C Unit		2014	3,550		15	237	237	1,066	21
22	Wandering Alarm System		2014	6,333		7	905	905	4,073	22
23	Exterior Painting of Building and Garage		2014	8,082		15	539	539	2,633	23
24	Parking Lot Repair, Exterior Repair, Room Sign Installation		2014	5,322		7	760	760	3,420	24
25	Storage Barn Shingle Replacement		2014	3,100		15	207	207	932	25
26	Ceramic Tile Replacement in Dining Room		2014	12,528		15	835	835	3,758	26
27	Water Heater-76 Gallon		2015	3,506		7	501	501	2,255	27
28	Air Conditioner-North Hall		2016	7,172		15	478	478	1,195	28
29	Refrigerator Repair		2016	2,566		7	366	366	915	29
30	Water Gallon-100 Gallon		2017	4,257		7	608	608	912	30
31	Remodeling in 2 Shower Rooms-Tiling, Walls Floor		2018	\$ 9,270	\$	15	\$ 309	\$ 309	\$ 309	31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

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					2,055		(2,055)	61
62					8,326		(8,326)	62
63					17,257		(17,257)	63
64								64
65					5,543	133	133	65
66					556	35	35	66
67								67
68								68
69								69
70								70
TOTAL (lines 4 thru 69)		\$ 448,496	\$ 27,638		\$ 22,498	\$ (5,140)	\$ 187,236	

**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	\$ 37,840	\$ 4,423	\$ 4,347	\$ (76)	5-10 yrs.	\$ 19,741	71
72	Current Year Purchases					7 yrs.		72
73	Fully Depreciated Assets	63,434					63,434	73
74	Home Office Allocation			6,778	6,778			74
75	TOTALS	\$ 101,274	\$ 4,423	\$ 11,125	\$ 6,702		\$ 83,175	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)	\$ 561,920	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,061	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 33,623	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,562	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 270,411	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	\$ 27,093	86
87	Exterior Painting of IL Building	6,255	417	1,876	87
88					88
89					89
90					90
91	TOTALS	\$ 56,219	\$ 2,424	\$ 28,969	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 Rehabilitation & Health Care Center

0053546

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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.	_____ /2019	\$ _____
13.	_____ /2020	\$ _____
14.	_____ /2021	\$ _____

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: \$ 20,227 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Sandwich Rehabilitation & Health Care Center

0053546

Period Beginning 1/1/2018

Period End 12/31/2018

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	15,069
Dishwasher		1,463
Copier		3,066
Home Office Allocation		629
		<u>20,227</u>

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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			
		1	2	3	4
		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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	3,216	\$ 48,240	\$	3,216	\$ 48,240	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		554	8,311		554	8,311	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,916	43,747		2,916	43,747	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				19,648		19,648	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			\$	6,686	\$ 100,298	\$ 19,648	6,686	\$ 119,946	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**

0053546

Report Period Beginning: **1/1/2018**

Ending:

12/31/2018

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2018**

(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	\$ (739,703)	\$ (739,703)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>259,451</u>)	2,024,173	2,024,173	3
4	Supply Inventory (priced at <u>Cost</u>)	6,178	6,178	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,929	15,929	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	136	136	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,306,713	\$ 1,306,713	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	231,543	14
15	Leasehold Improvements, at Historical Cost	283,946	216,953	15
16	Equipment, at Historical Cost	101,274	101,274	16
17	Accumulated Depreciation (book methods)	(338,132)	(270,411)	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 <u>Independent Living Facility</u>		27,250	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 297,407	\$ 318,759	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,604,120	\$ 1,625,472	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 370,251	\$ 370,251	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	43,603	43,603	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,796	60,796	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,556	8,556	31
32	Accrued Real Estate Taxes(Sch.IX-B)	125,351	125,351	32
33	Accrued Interest Payable	15,857	15,857	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	242,193	242,193	36
37	<u>Accrued Management Fees</u>	596,953	596,953	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,463,560	\$ 1,463,560	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	2,521,597	2,521,597	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Intercompany Loans</u>	36	36	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,521,633	\$ 2,521,633	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,985,193	\$ 3,985,193	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,381,073)	\$ (2,359,721)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,604,120	\$ 1,625,472	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,055,955)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	152	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,055,803)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(325,270)	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)	\$ (325,270)	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)	\$ (2,381,073)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center

0053546

Report Period Beginning: 1/1/2018

Ending: 12/31/2018

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	\$ 1,963,625	1
2	Discounts and Allowances for all Levels	(17,429)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,946,196	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	175,005	5
6	Therapy	188,953	6
7	Oxygen	398	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 364,356	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	504	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	35,152	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,504	20
21	Other Medical Services	4,389	21
22	Laundry	3,346	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 47,895	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	1,540	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,540	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	4,709	28
28a	<u>Miscellaneous Revenue</u>	3,007	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,716	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,367,703	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	588,274	31
32	Health Care	1,017,055	32
33	General Administration	404,978	33
B. Capital Expense			
34	Ownership	436,942	34
C. Ancillary Expense			
35	Special Cost Centers	146,543	35
36	Provider Participation Fee	99,181	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,692,973	40
41	Income before Income Taxes (line 30 minus line 40)**	(325,270)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (325,270)	43
III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,420,735	44
45	Private Pay - Net Inpatient Revenue	212,583	45
46	Medicare - Net Inpatient Revenue	312,878	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,946,196	49

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

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

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

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

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

0053546

Report Period Beginning: **1/1/2018**

Ending:

12/31/2018

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,883	1,883	\$ 60,590	\$ 32.18	1
2	Assistant Director of Nursing	869	869	27,313	31.43	2
3	Registered Nurses	8,634	8,712	237,059	27.21	3
4	Licensed Practical Nurses	3,104	3,204	63,344	19.77	4
5	CNAs & Orderlies	21,820	22,130	327,256	14.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	16	16	225	14.06	8
9	Activity Director	2,071	2,071	24,482	11.82	9
10	Activity Assistants					10
11	Social Service Workers	514	514	8,234	16.02	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	29,961	14.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,015	11,330	103,791	9.16	15
16	Dishwashers					16
17	Maintenance Workers	1,607	1,607	28,806	17.93	17
18	Housekeepers	8,549	8,838	104,126	11.78	18
19	Laundry	1,431	1,525	14,698	9.64	19
20	Administrator	2,177	2,177	73,728	33.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,017	2,017	33,115	16.42	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>Page 20A</u>	3,370	3,502	70,357	20.09	33
34	TOTAL (lines 1 - 33)	71,157	72,475	\$ 1,207,085 *	\$ 16.66	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 549	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 3,440	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)	\$ 20,789		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	145 \$ 6,416	L10, C3	50
51	Licensed Practical Nurses			51
52	Certified Nurse Assistants/Aides	539 17,247	L10, C3	52
53	TOTAL (lines 50 - 52)	684 \$ 23,663		53

Sandwich Rehabilitation & Health Care Center

0053546

Period Beginning 1/1/2018

Period End 12/31/2018

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	1,115	1,183	31,156	26.34
Transportation	1,435	1,435	21,846	15.22
Marketing	820	884	17,355	19.63
TOTAL	<u>3,370</u>	<u>3,502</u>	<u>70,357</u>	

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		
Elijah Vanowski	Administrator	0	\$ 7,159	Workers' Compensation Insurance	\$ 21,939	IDPH License Fee	\$ 1,990		
Ruth Jackson	Administrator	0	66,569	Unemployment Compensation Insurance	12,679	Advertising: Employee Recruitment	1,661		
				FICA Taxes	85,069	Health Care Worker Background Check			
				Employee Health Insurance	1,925	(Indicate # of checks performed <u>34</u>)	(53)		
				Employee Meals		Patient Background Checks			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Licenses & Permits	820		
				Employee Relations	2,016	Miscellaneous Dues & Subscriptions	580		
				Home Office Allocation	12,695	Home Office Allocation	2,904		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 73,728	TOTAL (agree to Schedule V, line 22, col.8)		\$ 136,323	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 7,727
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			\$ 202,300				Out-of-State Travel	\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 202,300	N/A			In-State Travel		
C. Professional Services				TOTAL			\$	Seminar Expense	
Vendor/Payee	Type		Amount				Home Office Allocation	1	
Comcast	Computer Services		\$ 1,328				Entertainment Expense	()	
Ability Network	Computer Services		1,073				TOTAL (agree to Sch. V, line 24, col. 8)		\$ 1
Duane Morris	Reversal of 2015 Fees		(8,006)						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ (5,605)						

* Attach copy of IMRF notifications

**See instructions.

Sandwich Rehabilitation & Health Care Center

0053546

Period Beginning

1/1/2018

Period End

12/31/2018

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

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		(5,605)

Home Office Allocation

Duane Morris	Legal	1184
Sedgwick CMS	Legal	105
SB2	Legal	292
Miscellaneous	Legal	87
Christoper P. Ryan	Legal	93
Saul Ewing Arnstein & Lehr	Legal	415
Healthcare Resources International	Legal	62
Winston & Strawn	Legal	998
Lexis Nexis	Legal	4
Pretzel & Stouffer	Legal	15
Baker Tilly Virchow Krause	Legal	235
Bank Leumi	Legal	2113
CliftonLarsonAllen	Accounting	606
Ginoli & Co.	Accounting	215
Duane Morris	Accounting	35
Getzler Henrich & Associates	Accounting	465
Kemper Consulting	Accounting	35
Baker Tilly Virchow Krause	Accounting	245
Ginoli & Co.	Accounting	1209
Miscellaneous	Computer Services	55
Change Healthcare	Computer Services	2
TR Professional	Computer Services	6
Matrix Care	Computer Services	680
Ability Network	Computer Services	1077
Stratus Networks	Computer Services	263
Kemper Technology	Computer Services	302
AT&T	Computer Services	4
Ungerboeck Software	Computer Services	218
CIAN	Computer Services	95
Comcast	Computer Services	23
CCH	Computer Services	9
Charter Communications	Computer Services	16
Allscripts	Computer Services	306
ATS	Computer Services	142
Citrix Systems	Computer Services	50
Optimizer	Other Prof Fees	28
Sedgwick CLMS	Other Prof Fees	96
David Budde	Other Prof Fees	27
Sargent Consulting	Other Prof Fees	75
Alix Partners	Other Prof Fees	286
Getzler Henrich & Associates	Other Prof Fees	39
Getzler Henrich & Associates	Other Prof Fees	2,079
DFH Capital	Other Prof Fees	499

Total (agree to Schedule V, line 19, column 8)		<u>9,185</u>
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**Sandwich Rehabilitation & Health Care Center
0053546**

Period Beginning 1/1/2018
Period End 12/31/2018

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	2,666
Auto Repairs		1,388
Mileage-Travel		2,264
Home Office Allocation		2,179
		<u>8,497</u>

Facility Name & ID Number Sandwich Rehabilitation & Health Care Center# 0053546Report Period Beginning: 1/1/2018Ending: 12/31/2018**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. IHCA-
- (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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 18,806 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 99,181
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. \$ 504
- (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. \$ 4,709
c. What percent of all travel expense relates to transportation of nurses and patients? 100
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? Yes
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 and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No
Attach invoices and a summary of services for all architect and appraisal fees

Sandwich Rehabilitation & Health Care Center

0053546

Period Beginning 1/1/2018

Period End 12/31/2018

Independent Living Offset

Schedule 23A

Census Days Summary:

	Days	%
Independent Living	4,834	29.09%
Nursing Home	11,785	70.91%
	<u>16,619</u>	<u>100.00%</u>

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Basis For Allocation	Line
Dietary	147,738	29.09%	42,973	Census	1
Food	118,259	29.09%	34,398	Census	2
Housekeeping	117,468	29.09%	34,168	Census	3
Laundry	26,417	29.09%	7,684	Census	4
Utilities	95,038	29.09%	27,644	Census	5
Maintenance	83,354	29.09%	24,245	Census	6
Depreciation (Building)	<u>2,424</u>	100.00%	<u>2,424</u>	Beds	30
Total	<u>590,698</u>		<u>173,536</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.