

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0053546

Facility Name: Sandwich Rehab HCC

Address: 902 East Arnold St Sandwich 60548
Number City Zip Code

County: Dekalb

Telephone Number: (815) 786-8409 Fax # (815) 786-3830

HFS ID Number:

Date of Initial License for Current Owners: 10/01/05

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 689-5850
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) Mark Petersen
(Title) Chief Executive Officer

Paid
Preparer

(Signed) _____ (Date) _____
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Sandwich Rehab HCC

0053546 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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 <u>N/A</u>					
	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	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>22,995</u>	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	<u>63</u>	TOTALS	<u>63</u>	<u>22,995</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,559</u>	<u>1,875</u>	<u>606</u>	<u>9,040</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,559</u>	<u>1,875</u>	<u>606</u>	<u>9,040</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 39.31%

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 606

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: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sandwich Rehab HCC # 0053546 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	121,940	13,267		135,207		135,207	(38,525)	96,682			1
2	Food Purchase		93,121		93,121		93,121	(28,929)	64,192			2
3	Housekeeping	110,424	14,696		125,120		125,120	(37,832)	87,288			3
4	Laundry		8,429		8,429		8,429	(2,552)	5,877			4
5	Heat and Other Utilities			91,921	91,921		91,921	(27,664)	64,257			5
6	Maintenance	33,197	10,513	43,002	86,712		86,712	(24,805)	61,907			6
7	Other (specify):*											7
8	TOTAL General Services	265,561	140,026	134,923	540,510		540,510	(160,307)	380,203			8
	B. Health Care and Programs											
9	Medical Director			16,800	16,800		16,800		16,800			9
10	Nursing and Medical Records	676,118	49,739	25,224	751,081		751,081	(572)	750,509			10
10a	Therapy			90,437	90,437		90,437		90,437			10a
11	Activities	15,192	672	(2,044)	13,820		13,820	(27)	13,793			11
12	Social Services	31,244			31,244		31,244		31,244			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	722,554	50,411	130,417	903,382		903,382	(599)	902,783			16
	C. General Administration											
17	Administrative	68,004		101,300	169,304		169,304	(87,914)	81,390			17
18	Directors Fees											18
19	Professional Services			8,261	8,261		8,261	9,615	17,876			19
20	Dues, Fees, Subscriptions & Promotions			2,013	2,013		2,013	1,057	3,070			20
21	Clerical & General Office Expenses	33,339	1,654	8,455	43,448		43,448	14,807	58,255			21
22	Employee Benefits & Payroll Taxes			128,221	128,221		128,221	4,097	132,318			22
23	Inservice Training & Education							25	25			23
24	Travel and Seminar							8	8			24
25	Other Admin. Staff Transportation			1,143	1,143		1,143	1,724	2,867			25
26	Insurance-Prop.Liab.Malpractice			46,327	46,327		46,327	263	46,590			26
27	Other (specify):*											27
28	TOTAL General Administration	101,343	1,654	295,720	398,717		398,717	(56,318)	342,399			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,089,458	192,091	561,060	1,842,609		1,842,609	(217,224)	1,625,385			29

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

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

Facility Name & ID Number Sandwich Rehab HCC #0053546 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			36,871	36,871		36,871	(2,531)	34,340			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,908	134,908		134,908	4,958	139,866			32
33	Real Estate Taxes			68,637	68,637		68,637	95	68,732			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,146	16,146		16,146	874	17,020			35
36	Other (specify):*											36
37	TOTAL Ownership			256,562	256,562		256,562	3,396	259,958			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,765		7,765		7,765		7,765			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,710	85,710		85,710		85,710			42
43	Other (specify):*		38	29,199	29,237		29,237	(29,237)				43
44	TOTAL Special Cost Centers		7,803	114,909	122,712		122,712	(29,237)	93,475			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,089,458	199,894	932,531	2,221,883		2,221,883	(243,065)	1,978,818			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(738)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,731)	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	(2,544)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(64)	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	(8,548)	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	(12,000)	43		24
25	Fund Raising, Advertising and Promotional	(2,138)	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	(165,960)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (201,723)		\$	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 Amount	2 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)	(41,342)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (41,342)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (243,065)		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 Yes	2 No	3 Amount	4 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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ 3,416	43	1
2	X-Rays-Part A	(106)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(2,827)	10	3
4	Offset Transportation Revenue	(27)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(118)	21	5
6	Disallowed Special Events	(66)	43	6
7	Disallowed Chamber of Commerce Dues	(175)	20	7
8	Independent Living Dietary Cost Offset	(40,932)	1	8
9	Independent Living Food Cost Offset	(28,191)	2	9
10	Independent Living Housekeeping Cost Offset	(37,879)	3	10
11	Independent Living Laundry Cost Offset	(2,552)	4	11
12	Independent Living Utilities Cost Offset	(27,828)	5	12
13	Independent Living Maintenance Cost Offset	(26,251)	6	13
14	Independent Living Depreciation Cost Offset	(2,424)	30	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
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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	(165,960)		49

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 2,407	\$ 2,407	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	47	47	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	164	164	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,446	1,446	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%	2,255	2,255	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	101,300	Petersen Health Care Management, Inc.	100.00%	13,386	(87,914)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	7,907	7,907	12
13	V								13
14	Total			\$ 101,300			\$ 27,612	\$ * (73,688)	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 Management, Inc.	100.00%	\$ 1,232	\$	1,232 15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	14,925		14,925 16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	4,097		4,097 17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	25		25 18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	8		8 19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	1,724		1,724 20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	263		263 21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	2,437		2,437 22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		0 23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	119		119 24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	95		95 25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	874		874 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			\$			\$ 25,799	\$ *	25,799 39

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

VII. RELATED PARTIES (continued)

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

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Business, LLC	100.00%	\$	\$	15
16	V	2	Food		Petersen Health Business, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Business, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Business, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Business, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Business, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Business, LLC	100.00%			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Business, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Business, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Business, LLC	100.00%	1,708	1,708	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Business, LLC	100.00%			26
27	V	21	Clerical and General Office		Petersen Health Business, LLC	100.00%			27
28	V	22	Employee Benefits & Payroll		Petersen Health Business, LLC	100.00%			28
29	V	23	Inservice Training & Education		Petersen Health Business, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Business, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Business, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Business, LLC	100.00%			32
33	V	30	Depreciation		Petersen Health Business, LLC	100.00%			33
34	V	31	Amortization		Petersen Health Business, LLC	100.00%			34
35	V	32	Interest		Petersen Health Business, LLC	100.00%	4,839	4,839	35
36	V	33	Real Estate Taxes		Petersen Health Business, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Business, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Business, LLC	100.00%			38
39	Total			\$			\$ 6,547	\$ * 6,547	39

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

Facility Name & ID Number

Sandwich Rehab HCC

0053546

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

Facility Name & ID Number

Sandwich Rehab HCC

0053546

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

Sandwich Rehab HCC

0053546

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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

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			Betty's Garden	Kewanee				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 Rehab HCC # 0053546 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Sandwich Rehab HCC# 0053546

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 ☐

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

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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	1	Dietary	Resident Days	1,282,791	75	\$ 341,562	\$ 398,718	9,040	\$ 2,407	1
2	2	Food	Resident Days	1,282,791	75	0	0	9,040	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	9,040	47	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	9,040	164	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	9,040	1,446	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	9,040	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	9,040	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	9,040	2,255	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	9,040	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	9,040	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	9,040	13,386	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	9,040	7,907	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	9,040	1,232	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	9,040	14,925	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	9,040	4,097	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	9,040	25	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	9,040	8	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	9,040	1,724	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	9,040	263	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	9,040	2,437	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	9,040	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	9,040	119	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	9,040	95	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	9,040	874	24
25	TOTALS					\$ 7,579,077	\$ 11,195,006		\$ 53,411	25

Facility Name & ID Number Sandwich Rehab HCC# 0053546

Report Period Beginning:

1/1/2020Ending: 2/31/2020

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 ☐

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

Name of Related Organization

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	70,323	9	\$	\$	5,500	\$	1
2	2	Food	Resident Days	70,323	9			5,500		2
3	3	Housekeeping	Resident Days	70,323	9			5,500		3
4	4	Laundry	Resident Days	70,323	9			5,500		4
5	5	Utilities	Resident Days	70,323	9			5,500		5
6	6	Maintenance	Resident Days	70,323	9			5,500		6
7	7	Mgmt. Allocation of Benefits	Resident Days	70,323	9			5,500		7
8	10	Nursing and Medical Records	Resident Days	70,323	9			5,500		8
9	15	Mgmt. Allocation of Benefits	Resident Days	70,323	9			5,500		9
10	17	Administrative	Resident Days	70,323	9			5,500		10
11	19	Professional Services	Resident Days	70,323	9	21,833		5,500	1,708	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	70,323	9			5,500		12
13	21	Clerical and General Office	Resident Days	70,323	9			5,500		13
14	22	Employee Benefits & Payroll	Resident Days	70,323	9			5,500		14
15	23	Inservice Training & Education	Resident Days	70,323	9			5,500		15
16	24	Travel and Seminar	Resident Days	70,323	9			5,500		16
17	25	Other Admin. Staff Transport.	Resident Days	70,323	9			5,500		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	70,323	9			5,500		18
19	30	Depreciation	Resident Days	70,323	9			5,500		19
20	31	Amortization	Resident Days	70,323	9			5,500		20
21	32	Interest	Resident Days	70,323	9	61,870		5,500	4,839	21
22	33	Real Estate Taxes	Resident Days	70,323	9			5,500		22
23	34	Rent-Facility and Grounds	Resident Days	70,323	9			5,500		23
24	35	Rent-Equipment & Vehicles	Resident Days	70,323	9			5,500		24
25	TOTALS					\$ 83,703	\$		\$ 6,547	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		2		3	4	5	6		7	8	9	10	
	Name of Lender	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	\$ Paid			\$ 134,908	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 2,690,719	\$			\$ 134,908	9	
	B. Non-Facility Related*												
10												10	
11								Home Office Allocation-PHCM			119	11	
12								Home Office Allocation-PHB			4,839	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 4,958	14	
15	TOTALS (line 9+line14)						\$ 2,690,719	\$			\$ 139,866	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.)

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 2019 report.				\$	65,976	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.)				\$	66,309	2
3. Under or (over) accrual (line 2 minus line 1).				\$	333	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	68,304	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.)					95	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	68,732	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	66,161	8		
		2016	66,914	9		
		2017	61,694	10		
		2018	61,973	11		
		2019	66,309	12		
Accrual based on prior year tax bill.						

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2019	\$	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.

2019 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 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 19-25-252-015	Long-Term Care Facility	\$ 41,254.58	\$ 41,254.58
2. 19-25-252-016	Long-Term Care Facility	\$ 25,054.58	\$ 25,054.58
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 66,309.16	\$ 66,309.16

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

A. Square Feet: 14,626

B. General Construction Type: Exterior BrickFrame WoodNumber of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

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:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	94,961	2005	\$ 12,150	1
2					2
3	TOTALS	94,961		\$ 12,150	3

HFS 3745 (N-4-99)

IL478-2471

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
5										
6										
7										
8										
	Improvement Type**									
9	Sidewalks			2006	8,685		15	579	579	8,299
10	Remodel Nurses Station			2007	11,351		15	757	757	9,462
11	Sprinkler Head Replacement			2008	2,900		7			2,900
12	Sprinkler Modifications			2009	15,100		20	755	755	7,928
13	Water Heater			2009	4,100		5			4,100
14	Sewer Line Repair			2009	2,910		7			2,910
15	Furnace			2012	2,955		15	198	198	1,485
16	Water Heater-100 Gallon			2012	3,673		7	267	267	3,673
17	Parking Lot Sealcoat			2013	50,860		15	3,390	3,390	25,425
18	Grease Trap Installation			2013	29,500		15	1,966	1,966	14,745
19	Concrete Repair			2013	2,747		7	199	199	2,747
20	Flooring and Carpeting-Lobby and Dining Hall			2013	15,930		15	1,062	1,062	6,903
21	A/C Unit			2014	3,550		15	237	237	1,540
22	Wandering Alarm System			2014	6,333		7	905	905	5,883
23	Exterior Painting of Building and Garage			2014	8,082		15	539	539	3,711
24	Parking Lot Repair, Exterior Repair, Room Sign Installation			2014	5,322		7	760	760	4,940
25	Storage Barn Shingle Replacement			2014	3,100		15	207	207	1,346
26	Ceramic Tile Replacement in Dining Room			2014	12,528		15	835	835	5,428
27	Water Heater-76 Gallon			2015	3,506		7	501	501	3,257
28	Air Conditioner-North Hall			2016	7,172		15	478	478	2,151
29	Refrigerator Repair			2016	2,566		7	366	366	1,647
30	Water Gallon-100 Gallon			2017	4,257		7	608	608	2,128
31	Remodeling in 2 Shower Rooms-Tiling, Walls Floor			2018	\$ 9,270	\$	15	\$ 618	618	1,545
32	Ceramic Tile Replacement in Bathrooms			2019	10,722		15	714	714	1,071
33	Furnace			2019	4,007		15	268	268	402
34	Water Heater			2019	5,648		15	376	376	564
35	Air Conditoners			2019	9,181		15	612	612	918
36										

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Sandwich Rehab HCC

0053546

Report Period Beginning:

1/1/2020

Ending:

12/31/2020

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 Sprinkler Head Replacement	2019	\$ 12,875	\$	7	\$ 1,840	\$ 1,840	\$ 2,269	37
38 Nursing System Equipment	2019	9,280		7	1,326	1,326	1,989	38
39 Sprinkler Head Replacement	2020	12,875		7	920	920	920	39
40 Flooring in Kitchen	2020	6,191		5	619	619	619	40
41 Water Heater	2020	8,147		7	582	582	582	41
42 Roof Replacement	2020	37,800		25	756	756	756	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 Land Improvements Booked			1,888			(1,888)		57
58 Building Booked			8,326			(8,326)		58
59 Building Improvement Booked			23,025			(23,025)		59
60								60
61 2020-Home Office Allocation-Building Improvements		4,571			110	110		61
62 2020-Home Office Allocation-Land Improvements		458			29	29		62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 564,152	\$ 33,239		\$ 30,341	\$ (2,898)	\$ 228,230	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	\$ 30,963	\$ 3,575	\$ 3,659	\$ 84	5-10 yrs.	\$ 20,522	71
72	Current Year Purchases	4,754	57	340	283	7 yrs.	340	72
73	Fully Depreciated Assets	70,311					70,311	73
74	Home Office Allocation							74
75	TOTALS	\$ 106,028	\$ 3,632	\$ 3,999	\$ 367		\$ 91,173	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	682,330
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	36,871
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	34,340
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(2,531)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	319,403

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	\$ 31,107	86
87	Exterior Painting of IL Building	6,255	417	2,710	87
88					88
89					89
90					90
91	TOTALS	\$ 56,219	\$ 2,424	\$ 33,817	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			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.

		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

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:

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 17,020 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 Rehab HCC
0053546
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 14A

XII. Rental Costs
 B. Equipment
 16. Description of rental amount for movable equipment

Medical Equipment	\$	9,851
Dishwasher		1,211
Copier		5,084
Home Office Allocation		874
		<u>17,020</u>

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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)	\$			

- (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.

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	

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

		1	2	3	4	5	6	7	8	
	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	\$	2,789	\$ 41,832	\$	2,789	\$ 41,832	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		836	12,546		836	12,546	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		2,404	36,059		2,404	36,059	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				7,765		7,765	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	6,029	\$ 90,437	\$ 7,765	6,029	\$ 98,202	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.

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	\$ 534,377	\$ 534,377	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 185,374)	1,567,224	1,567,224	3
4	Supply Inventory (priced at Cost)	6,178	6,178	4
5	Short-Term Investments			5
6	Prepaid Insurance	25,830	25,830	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Education Loans	1,990	1,990	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,135,599	\$ 2,135,599	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	43,119	12,150	13
14	Buildings, at Historical Cost	207,350	230,571	14
15	Leasehold Improvements, at Historical Cost	378,517	333,581	15
16	Equipment, at Historical Cost	106,028	106,028	16
17	Accumulated Depreciation (book methods)	(407,041)	(319,403)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Independent Living Facility		22,402	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 327,973	\$ 385,329	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,463,572	\$ 2,520,928	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 509,469	\$ 509,469	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	47,211	47,211	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	68,304	68,304	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	58,390	58,390	36
37	Accrued Management Fees	165	165	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 683,539	\$ 683,539	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44	Loan Payable-MCAD Adv. Payment	1,100,000	1,100,000	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,100,000	\$ 1,100,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,783,539	\$ 1,783,539	46
47	TOTAL EQUITY (page 18, line 24)	\$ 680,033	\$ 737,389	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,463,572	\$ 2,520,928	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,381,073)	1
2	Restatements (describe):		2
3	Adjustments Made After Cost Reports Were Filed	2,677,709	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 296,636	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	383,397	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)	\$ 383,397	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)	\$ 680,033	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Sandwich Rehab HCC

0053546

Report Period Beginning: 1/1/2020

Ending: 12/31/2020

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	\$ 1,936,966	1
2	Discounts and Allowances for all Levels	(259,288)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,677,678	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients	152,679	5
6	Therapy	166,027	6
7	Oxygen	1,033	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 319,739	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	738	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	12,662	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,528	20
21	Other Medical Services	10,890	21
22	Laundry	3,247	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 29,065	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	27	28
28a	Miscellaneous and COVID Stimulus Revenue	578,771	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 578,798	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,605,280	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	540,510	31
32	Health Care	903,382	32
33	General Administration	398,717	33
	B. Capital Expense		
34	Ownership	256,562	34
	C. Ancillary Expense		
35	Special Cost Centers	37,002	35
36	Provider Participation Fee	85,710	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,221,883	40
41	Income before Income Taxes (line 30 minus line 40)**	383,397	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 383,397	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 868,211	44
45	Private Pay - Net Inpatient Revenue	559,892	45
46	Medicare - Net Inpatient Revenue	249,575	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,677,678	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.

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	1,427	1,427	\$ 44,487	\$ 31.18	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,003	9,113	255,333	28.02	3
4	Licensed Practical Nurses	226	226	5,136	22.73	4
5	CNAs & Orderlies	20,425	21,039	318,718	15.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	729	754	9,126	12.10	9
10	Activity Assistants	606	606	6,066	10.01	10
11	Social Service Workers	2,058	2,116	31,244	14.77	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	33,900	16.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,760	8,012	88,040	10.99	15
16	Dishwashers					16
17	Maintenance Workers	1,748	1,807	33,197	18.37	17
18	Housekeepers	9,532	9,837	110,424	11.23	18
19	Laundry					19
20	Administrator	2,048	2,080	68,004	32.69	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,960	2,038	33,339	16.36	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) CPC	1,632	1,632	52,444	32.13	33
34	TOTAL (lines 1 - 33)	61,234	62,767	\$ 1,089,458 *	\$ 17.36	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	16,800	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,721	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	1	63	L10, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1	\$ 19,584		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	584	\$ 18,825	L10,C3	50
51	Licensed Practical Nurses	57	1,723	L10,C3	51
52	Certified Nurse Assistants/Aides	107	1,892	L10,C3	52
53	TOTAL (lines 50 - 52)	748	\$ 22,440		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount
Jacob Valle	Administrator	0	\$ 68,004	Workers' Compensation Insurance		\$ 20,098	IDPH License Fee		\$
				Unemployment Compensation Insurance		10,167	Advertising: Employee Recruitment		
				FICA Taxes		77,061	Health Care Worker Background Check		
				Employee Health Insurance		5,888	(Indicate # of checks performed 14)		
				Employee Meals			Patient Background Checks 22		670
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		1,168
				Employee Relations		1,411	Miscellaneous Dues & Subscriptions		175
				Home Office Allocation		4,097	Home Office Allocation		1,232
				Administrator Benefits		13,596			
							Less: Public Relations Expense		(175)
							Non-allowable advertising		()
							Yellow page advertising		()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)							TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,070
B. Administrative - Other									
Description			Amount						
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 101,300						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 101,300						
C. Professional Services									
Vendor/Payee	Type		Amount	Description		Line #	Amount		
Comcast	Computer Services		\$ 1,360				\$		
Ability Network	Computer Services		6,901						
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 8,261	TOTAL			\$		

*** Attach copy of IMRF notifications**

****See instructions.**

Sandwich Rehab HCC

0053546

Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		8,261

Home Office Allocation

Baker Tilly Virchow Krause LLP	Legal	139
Duane Morris	Legal	195
Lexis Nexis	Legal	4
Livingston, Barger, Brant, Schroeder	Legal	7
Miller, Hall, Triggs	Legal	24
Miscellaneous	Legal	9
SB2	Legal	72
SmithAmundsen LLC	Legal	445
Sorling Northrup	Legal	127
Sector Bank	Legal	1,312
CliftonLarsonAllen	Accounting	553
Ginoli & Co.	Accounting	791
Ability Network	Computer Services	1,419
Allscripts	Computer Services	224
AOD Matrix Care	Computer Services	2,492
AT&T	Computer Services	3
ATS	Computer Services	136
CCH	Computer Services	8
Charter Communications	Computer Services	13
Citrix Systems	Computer Services	42
Comcast	Computer Services	15
ITSavvy	Computer Services	66
Kemper Technology	Computer Services	324
Miscellaneous	Computer Services	63
Pearl Technology	Computer Services	59
Stratus Networks	Computer Services	257
TR Professional	Computer Services	6
David Budde	Other Prof Fees	6
DJ Howard and Associates	Other Prof Fees	11
Getzler Henrich & Associates	Other Prof Fees	44
LRI Consulting Services	Other Prof Fees	43
McQuellon Consulting	Other Prof Fees	27
Miscellaneous	Other Prof Fees	46
Optimizer	Other Prof Fees	23
Registered Agent Solutions	Other Prof Fees	13
RSM McGladrey	Other Prof Fees	141
SB2	Other Prof Fees	180
Sedgwick CMS	Other Prof Fees	242
Tarver Program Consultants	Other Prof Fees	34

Total (agree to Schedule V, line 19, column 8)	<u>17,876</u>
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Sandwich Rehab HCC
0053546
Period Beginning 1/1/2020
Period End 12/31/2020

Schedule 21B

25. Administrative and Staff Transportation

Gas	\$	316
Auto Repairs		629
Mileage-Travel		198
Home Office Allocation		<u>1,724</u>
		<u><u>2,867</u></u>

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? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,905 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. \$ 85,710
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. \$ 738
- (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. \$ 27
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
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? _____
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 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 Rehab HCC
053546
Period Beginning 1/1/2020
Period End 12/31/2020

Independent Living Offset

Schedule 23A

Census Days Summary:	Days	%
Independent Living	3,925	30.27%
Nursing Home	9,040	69.73%
	12,965	100.00%

Expense Offset:	Total Amount	Ind. Liv %	Ind. Liv Offset	Allocation Basis	Line
Dietary	135,207	30.27%	40,932	Census	1
Food	93,121	30.27%	28,191	Census	2
Housekeeping	125,120	30.27%	37,879	Census	3
Laundry	8,429	30.27%	2,552	Census	4
Utilities	91,921	30.27%	27,828	Census	5
Maintenance	86,712	30.27%	26,251	Census	6
Depreciation (Building)	2,424	100.00%	2,424	Beds	30
Total	542,934		166,057		

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.