		FOR BHF USE					

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0049148

Facility Name: Marigold Rehab & Health Care Center

Address: 275 E. Carl Sandburg Dr. (Number) Galesburg (City) 61401 (Zip Code)

County: Knox

Telephone Number: (309) 344-1151 Fax # (309) 344-2007

HFS ID Number:

Date of Initial License for Current Owners: 1/31/2008

Type of Ownership:

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

- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [ ] "Sub-S" Corp.
  - [X] Limited Liability Co.
  - [ ] Trust
  - [ ] Other

- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 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 B. 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

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (309) 689-5869
Email Address:

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	172	Skilled (SNF)	172	62,780	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	172	TOTALS	172	62,780	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	33,852	5,203	7,016	46,071	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	33,852	5,203	7,016	46,071	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.38%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

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 [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

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

I. On what date did you start providing long term care at this location?
Date started 1/31/2008

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/31/2008 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 172 and days of care provided 6,070

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number: Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	259,220	32,376		291,596		291,596	8,581	300,177			1
2	Food Purchase		260,215		260,215		260,215	(15,711)	244,504			2
3	Housekeeping	146,555	46,958		193,513		193,513	102	193,615			3
4	Laundry	31,396	24,846		56,242		56,242		56,242			4
5	Heat and Other Utilities			149,316	149,316		149,316	853	150,169			5
6	Maintenance	53,007	23,423	57,068	133,498		133,498	4,995	138,493			6
7	Other (specify):* Home Off. Ben. All.							2,011	2,011			7
8	TOTAL General Services	490,178	387,818	206,384	1,084,380		1,084,380	831	1,085,211			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,076,403	202,538	10,520	2,289,461		2,289,461	(116)	2,289,345			10
10a	Therapy	25,033	1,530	722,568	749,131		749,131		749,131			10a
11	Activities	99,349	1,011	2,385	102,745		102,745	(5,679)	97,066			11
12	Social Services	69,231			69,231		69,231		69,231			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	2,270,016	205,079	753,473	3,228,568		3,228,568	(5,795)	3,222,773			16
	C. General Administration											
17	Administrative			722,500	722,500		722,500	(649,647)	72,853			17
18	Directors Fees											18
19	Professional Services			5,603	5,603		5,603	14,380	19,983			19
20	Dues, Fees, Subscriptions & Promotions			12,417	12,417		12,417	9,969	22,386			20
21	Clerical & General Office Expenses	87,437	31,421	37,853	156,711		156,711	109,259	265,970			21
22	Employee Benefits & Payroll Taxes			457,435	457,435		457,435	17,413	474,848			22
23	Inservice Training & Education			225	225		225	614	839			23
24	Travel and Seminar			715	715		715	71	786			24
25	Other Admin. Staff Transportation			15,003	15,003		15,003	7,686	22,689			25
26	Insurance-Prop.Liab.Malpractice			66,361	66,361		66,361	1,274	67,635			26
27	Other (specify):* Home Off. Ben. All.							34,854	34,854			27
28	TOTAL General Administration	87,437	31,421	1,318,112	1,436,970		1,436,970	(454,127)	982,843			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,847,631	624,318	2,277,969	5,749,918		5,749,918	(459,091)	5,290,827			29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			335,838	335,838		335,838	(99,610)	236,228			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			241,010	241,010		241,010	26,855	267,865			32
33	Real Estate Taxes			156,264	156,264		156,264	(3,948)	152,316			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			45,994	45,994		45,994	1,179	47,173			35
36	Other (specify):*											36
37	**TOTAL Ownership**			779,106	779,106		779,106	(75,524)	703,582			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		274,777		274,777		274,777		274,777			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):* Non-allowable Cost		952	100,292	101,244		101,244	(101,244)				43
44	**TOTAL Special Cost Centers**		275,729	194,462	470,191		470,191	(101,244)	368,947			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,847,631	900,047	3,251,537	6,999,215		6,999,215	(635,859)	6,363,356			45

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,797)	2		4
5	Telephone, TV & Radio in Resident Rooms		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	(109,495)	30		9
10	Interest and Other Investment Income	(4,087)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(809)	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				18
19	Entertainment				19
20	Contributions	(50,750)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(6,324)	43		24
25	Fund Raising, Advertising and Promotional	(21,175)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(38,847)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (243,284)		$	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)	(392,575)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (392,575)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (635,859)		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.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Marigold Rehab & Health Care Center

ID# 0049148

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

NON-ALLOWABLE EXPENSES

		Amount	Sch. V Line Reference	
1	Labs-Part A	$ (10,359)	43	1
2	X-Rays-Part A	(9,270)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(247)	10	3
4	Offset Vending Machine Income	(3,914)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(1,287)	21	5
6	Offset Chamber of Commerce Dues	(367)	20	6
7	Pet Expense	(951)	43	7
8	Disallowed Special Events	(79)	43	8
9	Offset Transportation Revenue	(5,679)	11	9
10	Resident Flowers	(1,527)	43	10
11	Disallowed Real Estate Tax Late Fees	(5,167)	33	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(38,847)		49

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 8,581	$ 8,581	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	102	102	3
4	V	4	Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5	Utilities		Petersen Health Care, Inc.	100.00%	853	853	5
6	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	4,995	4,995	6
7	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	2,011	2,011	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	131	131	8
9	V	11	Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative	722,500	Petersen Health Care, Inc.	100.00%	72,853	(649,647)	11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	9,508	9,508	12
13	V								13
14	Total			$ 722,500			$ 99,034	$ * (623,466)	14

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs and Promotions	$	Petersen Health Care, Inc.	100.00%	$ 2,355	$ 2,355	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	85,411	85,411	16
17	V	23	Inservice Training and Education		Petersen Health Care, Inc.	100.00%	614	614	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	71	71	18
19	V	25	Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	7,686	7,686	19
20	V	26	Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,274	1,274	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	34,854	34,854	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	9,885	9,885	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	11,392	11,392	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	1,219	1,219	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	1,179	1,179	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			$			$ 155,940	$ * 155,940	39

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] 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 Care V, LLC	100.00%	$	$	15
16	V	2	Food		Petersen Health Care V, LLC	100.00%			16
17	V	3	Housekeeping		Petersen Health Care V, LLC	100.00%			17
18	V	4	Laundry		Petersen Health Care V, LLC	100.00%			18
19	V	5	Utilities		Petersen Health Care V, LLC	100.00%			19
20	V	6	Maintenance		Petersen Health Care V, LLC	100.00%			20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%			21
22	V	10	Nursing and Medical Records		Petersen Health Care V, LLC	100.00%			22
23	V	15	Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%			23
24	V	17	Administrative		Petersen Health Care V, LLC	100.00%			24
25	V	19	Professional Services		Petersen Health Care V, LLC	100.00%	4,872	4,872	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care V, LLC	100.00%	7,981	7,981	26
27	V	21	Clerical and General Office		Petersen Health Care V, LLC	100.00%	25,135	25,135	27
28	V	22	Employee Benefits & Payroll		Petersen Health Care V, LLC	100.00%	17,413	17,413	28
29	V	23	Inservice Training & Education		Petersen Health Care V, LLC	100.00%			29
30	V	24	Travel and Seminar		Petersen Health Care V, LLC	100.00%			30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care V, LLC	100.00%			31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care V, LLC	100.00%			32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%			33
34	V	30	Depreciation		Petersen Health Care V, LLC	100.00%			34
35	V	32	Interest		Petersen Health Care V, LLC	100.00%	19,550	19,550	35
36	V	33	Real Estate Taxes		Petersen Health Care V, LLC	100.00%			36
37	V	34	Rent-Facility and Grounds		Petersen Health Care V, LLC	100.00%			37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care V, LLC	100.00%			38
39	Total			$			$ 74,951	$ * 74,951	39

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
					Compensation Received From Other	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Mark Petersen	President	Administrative	100.00	176,397	1.76	2.93	Salary	$ 5,853	L17, C7	1
2											2
3											3
4											4
5		See Attached Schedule 7A									5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 5,853		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 Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 X NO

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

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

	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	1,527,029	77	$ 284,427	$ 283,010	46,071	$ 8,581	1
2	2	Food	Resident Days	1,527,029	77	0	0	46,071	0	2
3	3	Housekeeping	Resident Days	1,527,029	77	3,369	0	46,071	102	3
4	4	Laundry	Resident Days	1,527,029	77	0	0	46,071	0	4
5	5	Utilities	Resident Days	1,527,029	77	28,267	0	46,071	853	5
6	6	Maintenance	Resident Days	1,527,029	77	165,545	121,901	46,071	4,995	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	66,650	0	46,071	2,011	7
8	10	Nursing and Medical Records	Resident Days	1,527,029	77	4,339	0	46,071	131	8
9	10A	Therapy	Resident Days	1,527,029	77	0	0	46,071	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	0	0	46,071	0	10
11	17	Administrative	Resident Days	1,527,029	77	5,157,152	5,157,152	46,071	72,853	11
12	19	Professional Services	Resident Days	1,527,029	77	315,156	0	46,071	9,508	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,527,029	77	78,050	0	46,071	2,355	13
14	21	Clerical and General Office	Resident Days	1,527,029	77	2,830,968	2,420,380	46,071	85,411	14
15	23	Inservice Training & Education	Resident Days	1,527,029	77	20,336	0	46,071	614	15
16	24	Travel and Seminar	Resident Days	1,527,029	77	2,344	0	46,071	71	16
17	25	Other Admin. Staff Transport.	Resident Days	1,527,029	77	254,752	0	46,071	7,686	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,527,029	77	42,233	0	46,071	1,274	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,527,029	77	1,155,252	0	46,071	34,854	19
20	30	Depreciation	Resident Days	1,527,029	77	327,648	0	46,071	9,885	20
21	32	Interest	Resident Days	1,527,029	77	377,597	0	46,071	11,392	21
22	33	Real Estate Taxes	Resident Days	1,527,029	77	40,405	0	46,071	1,219	22
23	34	Rent-Facility and Grounds	Resident Days	1,527,029	77	0	0	46,071	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,527,029	77	39,061	0	46,071	1,179	24
25	TOTALS					$ 11,193,551	$ 7,982,443		$ 254,974	25

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 X NO

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	63,500	2	$	$	46,071	$	1
2	2	Food	Resident Days	63,500	2			46,071		2
3	3	Housekeeping	Resident Days	63,500	2			46,071		3
4	4	Laundry	Resident Days	63,500	2			46,071		4
5	5	Utilities	Resident Days	63,500	2			46,071		5
6	6	Maintenance	Resident Days	63,500	2			46,071		6
7	7	Mgmt. Allocation of Benefits	Resident Days	63,500	2			46,071		7
8	10	Nursing and Medical Records	Resident Days	63,500	2			46,071		8
9	10A	Therapy	Resident Days	63,500	2			46,071		9
10	15	Mgmt. Allocation of Benefits	Resident Days	63,500	2			46,071		10
11	17	Administrative	Resident Days	63,500	2			46,071		11
12	19	Professional Services	Resident Days	63,500	2	6,715		46,071	4,872	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	63,500	2	11,000		46,071	7,981	13
14	21	Clerical and General Office	Resident Days	63,500	2	34,644		46,071	25,135	14
15	22	Employee Benefits & Payroll	Resident Days	63,500	2	24,000		46,071	17,413	15
16	24	Travel and Seminar	Resident Days	63,500	2			46,071		16
17	25	Other Admin. Staff Transport.	Resident Days	63,500	2			46,071		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	63,500	2			46,071		18
19	27	Mgmt. Allocation of Benefits	Resident Days	63,500	2			46,071		19
20	30	Depreciation	Resident Days	63,500	2			46,071		20
21	32	Interest	Resident Days	63,500	2	26,946		46,071	19,550	21
22	33	Real Estate Taxes	Resident Days	63,500	2			46,071		22
23	34	Rent-Facility and Grounds	Resident Days	63,500	2			46,071		23
24	35	Rent-Equipment & Vehicles	Resident Days	63,500	2			46,071		24
25	TOTALS					$ 103,305	$		$ 74,951	25

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	The Private Bank		X	Mortgage	Varies	4/15/08	$ 4,554,000	$ 4,337,479	4/15/13	0.0404	$ 226,603	1
2												2
3							Interest Income Offset				(4,087)	3
4							Home Office Allocation-PHC				11,392	4
5							Home Office Allocation-PHC V				19,550	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 4,554,000	$ 4,337,479			$ 253,458	9
	B. Non-Facility Related*											
10							Amortization of Loan Costs				14,407	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 14,407	14
15	TOTALS (line 9+line14)						$ 4,554,000	$ 4,337,479			$ 267,865	15

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

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

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

Description		Amount	Line
1. Real Estate Tax accrual used on 2009 report.		$ 128,700	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.)	2009	$ 137,797	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,097	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 142,000	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.)**	Home Office Allocation	1,219 $	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 152,316	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		Line
2005		8
2006		9
2007		10
2008	122,868	11
2009	137,797	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marigold Rehab & Health Care Center COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049148

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	95-34-477-004	Long-Term Care Facility	$ 137,796.98	$ 137,796.98
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 137,796.98	$ 137,796.98

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 46,654 B. General Construction Type: Exterior Brick & Block Frame Wood Number of Stories 1

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

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

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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	46,584	2008	$ 583,785	1
2					2
3	TOTALS	46,584		$ 583,785	3

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	172		2008	1971	$ 4,364,724	$	39	$ 111,916	$ 111,916	$ 279,790	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Generator Repair			2008	2,787		7	400	400	1,000	9
10	Water Heater			2008	7,200		5	1,440	1,440	3,600	10
11	Water Heater			2008	9,600		5	1,920	1,920	4,800	11
12	Sprinkler System Repair			2008	15,370		7	2,196	2,196	5,490	12
13	Roof Repair			2009	3,819		7	546	546	819	13
14	Parking Lot Resurfacing			2010	11,825		15	394	394	394	14
15	Sewer Line Repair			2010	4,338		7	310	310	310	15
16	Electrical Repair			2010	11,011		7	787	787	787	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	Land Improvements Booked					394			(394)		30
31	Building Booked					174,589			(174,589)		31
32	Building Improvement Booked					6,996			(6,996)		32
33											33
34	2010-Home Office Allocation-Land Improvements				2,067			115	115		34
35	2010-Home Office Allocation-Building Improvements				22,144			531	531		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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,454,885	$ 181,979		$ 120,555	$ (61,424)	$ 296,990	70

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 905,613	$ 129,373	$ 90,562	$ (38,811)	10 yrs.	$ 224,777	71
72	Current Year Purchases	304,513	24,486	15,226	(9,260)	10 yrs.	15,226	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			9,885	9,885			74
75	TOTALS	$ 1,210,126	$ 153,859	$ 115,673	$ (38,186)		$ 240,003	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,248,796	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 335,838	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 236,228	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (99,610)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 536,993	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		$	$	$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	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.

Facility Name & ID Number: Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

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: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 47,173 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			N/A		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.

Marigold Rehab & Health Care Center
0049148
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 14A

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

Description	Amount
Medical Equipment	$ 40,609
Dishwasher	956
Laundry Equipment	745
Copier	3,684
Home Office Allocation	1,179
	47,173

Facility Name & ID Number: Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

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

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)	$			

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.)

		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	$	20,485	$ 307,279	$	20,485	$ 307,279	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,392	50,876		3,392	50,876	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		24,247	363,698	1,530	24,247	365,228	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				274,777		274,777	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			48	715		48	715	13
14	TOTAL			$	48,172	$ 722,568	$ 276,307	48,172	$ 998,875	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.

STATE OF ILLINOIS

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 233,183	$ 233,183	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 150,000)	964,619	964,619	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,900	44,900	6
7	Other Prepaid Expenses	21,928	21,928	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,264,630	$ 1,264,630	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	595,610	583,785	13
14	Buildings, at Historical Cost	4,364,724	4,386,868	14
15	Leasehold Improvements, at Historical Cost	54,125	68,017	15
16	Equipment, at Historical Cost	1,210,126	1,210,126	16
17	Accumulated Depreciation (book methods)	(924,450)	(536,993)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe **Loan Costs**	32,415	32,415	22
23	Other(specify): **A/R-Prior Owner**	54,708	54,708	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,387,258	$ 5,798,926	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,651,888	$ 7,063,556	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 799,727	$ 799,727	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	187,648	187,648	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,087	20,087	31
32	Accrued Real Estate Taxes(Sch.IX-B)	142,000	142,000	32
33	Accrued Interest Payable	7,766	7,766	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Payroll Withholdings**	69,216	69,216	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,226,444	$ 1,226,444	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,337,479	4,337,479	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,337,479	$ 4,337,479	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,563,923	$ 5,563,923	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,087,965	$ 1,499,633	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,651,888	$ 7,063,556	48

*(See instructions.)

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 363,065	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 363,064	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	724,901	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)**	$ 724,901	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)**	$ 1,087,965	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,778,690	1
2	Discounts and Allowances for all Levels	(566,289)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,212,401	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	975,452	6
7	Oxygen	1,211	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 976,663	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	1,705	13
14	Non-Patient Meals	11,797	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	465,345	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	20,168	20
21	Other Medical Services	20,823	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 519,838	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,087	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,087	26
	E. Other Revenue (specify):** **		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation & Miscellaneous Revenue	7,213	28
28a	Vending Maching Income	3,914	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,127	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,724,116	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,084,380	31
32	Health Care	3,228,568	32
33	General Administration	1,436,970	33
	B. Capital Expense		
34	Ownership	779,106	34
	C. Ancillary Expense		
35	Special Cost Centers	376,021	35
36	Provider Participation Fee	94,170	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,999,215	40
41	**Income before Income Taxes (line 30 minus line 40)****	724,901	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 724,901	43

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

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

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

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

STATE OF ILLINOIS

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 55,484	$ 26.68	1
2	Assistant Director of Nursing	3,221	3,277	48,305	14.74	2
3	Registered Nurses	6,408	6,983	168,158	24.08	3
4	Licensed Practical Nurses	38,236	40,216	689,282	17.14	4
5	CNAs & Orderlies	83,614	87,808	940,124	10.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,789	1,974	25,033	12.68	8
9	Activity Director	1,791	1,975	33,300	16.86	9
10	Activity Assistants	2,401	2,634	39,030	14.82	10
11	Social Service Workers	3,865	4,169	69,231	16.61	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	47,429	22.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,283	23,791	211,791	8.90	15
16	Dishwashers					16
17	Maintenance Workers	2,822	4,094	53,007	12.95	17
18	Housekeepers	15,897	16,188	146,555	9.05	18
19	Laundry	3,626	3,698	31,396	8.49	19
20	Administrator	2,080	2,080	67,000	32.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,720	7,077	87,437	12.36	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	2,323	2,499	38,911	15.57	31
32	Other Health Care(specify)					32
33	Other(specify) See Sch 20A	9,305	9,969	163,158	16.37	33
34	TOTAL (lines 1 - 33)	210,541	222,592	$ 2,914,631 *	$ 13.09	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	18,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	7,245	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 25,245		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Marigold Rehab & Health Care Center

Period Beginning **1/1/2010**
Period End **12/31/2010**

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	4,452	4,716	102,737	21.78
Alzheimer's Coordinator	2,870	3,130	33,402	10.67
Transportation	1,983	2,123	27,019	12.73
Marketing	-	-	-	
TOTAL	9,305	9,969	163,158	

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Crystal Crain	Administrator	0	$ 67,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 67,000

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 722,500
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 722,500

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 4,500
CenturyLink	Computer Services	1,232
Peoria Circuit Clerk	Legal Services	246
Emdeon Business Services	Reversal of Prior Year Fees	(375)
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 5,603

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 67,583
Unemployment Compensation Insurance	40,956
FICA Taxes	213,061
Employee Health Insurance	63,332
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	87,205
Life Insurance	92
Employee Retirement	2,619
TOTAL (agree to Schedule V, line 22, col.8)	$ 474,848

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description		Amount
IDPH License Fee		$ 1,990
Advertising: Employee Recruitment		174
Health Care Worker Background Check (Indicate # of checks performed)		
Patient Background Checks	316	3,161
Miscellaneous Licenses & Permits		1,750
Miscellaneous Dues & Subscriptions		377
IHCA Dues		2,400
Home Office Allocation		10,336
Curaspan Health Group		2,565
Less: Public Relations Expense		(367)
Non-allowable advertising		( )
Yellow page advertising		( )
TOTAL (agree to Sch. V, line 20, col. 8)		$ 22,386

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	715
Home Office Allocation	71
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 786

**See instructions.

Marigold Rehab & Health Care Center
0049148
Period Beginning 1/1/2010
Period End 12/31/2010

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,603
Home Office Allocation		
Heyl, Royster, Voelker & Allen	Legal	9
Healthcare Resources International	Legal	117
Ginoli & Company	Accountants	6,553
Bank of America	Accountants	370
Miscellaneous Vendors	Computer Services	54
VisionShare	Computer Services	506
Advanced Answers on Demand	Computer Services	3,179
Access 2 Go	Computer Services	517
Kemper Technology	Computer Services	438
MediFax	Computer Services	181
LogmeIn	Computer Services	129
Simple LTC	Computer Services	2,027
Optimizer Systems	Other Professional Fees	73
Clifton Gunderson	Other Professional Fees	227
Total (agree to Schedule V, line 19, column 8)		19,983

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Marigold Rehab & Health Care Center** **#** **0049148** **Report Period Beginning:** **1/1/2010** **Ending:** **12/31/2010**

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. **2,400** **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? **10 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,188** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **94,170**
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? **N/A** 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. $ **11,797**

(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. $ **5,679**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? **N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & 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) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.