FOR BHF USE

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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: 0052662

Facility Name: Marigold Rehabilitation HCC

Address: 275 E Carl Sandburg (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			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 1/1/14 to 12/31/14 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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	34,906	10,787	4,275	49,968	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,906	10,787	4,275	49,968	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.59%

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 [ ]

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 3,522

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 **Report Period Beginning:** 1/1/14 **Ending:** 12/31/14

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	265,326	24,636		289,962		289,962	16,889	306,851			1
2	Food Purchase		312,667		312,667		312,667	6,929	319,596			2
3	Housekeeping	164,531	51,092		215,623		215,623	104	215,727			3
4	Laundry	21,460	22,406		43,866		43,866		43,866			4
5	Heat and Other Utilities			152,229	152,229		152,229	634	152,863			5
6	Maintenance	53,992	29,784	36,878	120,654		120,654	6,350	127,004			6
7	Other (specify):* Home Off. Ben. All.											7
8	**TOTAL General Services**	505,309	440,585	189,107	1,135,001		1,135,001	30,906	1,165,907			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000	60	18,060			9
10	Nursing and Medical Records	2,185,931	199,693	20,985	2,406,609		2,406,609	(344)	2,406,265			10
10a	Therapy		37	483,531	483,568		483,568		483,568			10a
11	Activities	80,189	176	362	80,727		80,727	(12,144)	80,727			11
12	Social Services	78,042			78,042		78,042		78,042			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	**TOTAL Health Care and Programs**	2,344,162	199,906	522,878	3,066,946		3,066,946	(12,428)	3,066,662			16
	C. General Administration											
17	Administrative	30,307		475,400	505,707		505,707	(401,777)	103,930			17
18	Directors Fees											18
19	Professional Services			17,518	17,518		17,518	53,064	70,582			19
20	Dues, Fees, Subscriptions & Promotions			4,291	4,291		4,291	9,360	13,651			20
21	Clerical & General Office Expenses	65,627	13,099	45,253	123,979		123,979	187,626	311,605			21
22	Employee Benefits & Payroll Taxes			223,018	223,018		223,018	42,831	265,849			22
23	Inservice Training & Education			50	50		50	76	126			23
24	Travel and Seminar							66	66			24
25	Other Admin. Staff Transportation			45,447	45,447		45,447	10,255	55,702			25
26	Insurance-Prop.Liab.Malpractice			60,545	60,545		60,545	1,479	62,024			26
27	Other (specify):* Home Off. Ben. All.											27
28	**TOTAL General Administration**	95,934	13,099	871,522	980,555		980,555	(97,020)	883,535			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,945,405	653,590	1,583,507	5,182,502		5,182,502	(78,542)	5,116,104			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 Marigold Rehabilitation HCC #0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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			439,808	439,808		439,808	(119,198)	320,610			30
31	Amortization of Pre-Op. & Org.							14,836	14,836			31
32	Interest			283,900	283,900		283,900	57,542	341,442			32
33	Real Estate Taxes			149,616	149,616		149,616	589	150,205			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			59,840	59,840		59,840	2,498	62,338			35
36	Other (specify):*											36
37	**TOTAL Ownership**			933,164	933,164		933,164	(43,733)	889,431			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		130,542		130,542		130,542		130,542			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			400,118	400,118		400,118		400,118			42
43	Other (specify):*	33,354	5,036	117,165	155,555		155,555	(155,555)				43
44	**TOTAL Special Cost Centers**	33,354	135,578	517,283	686,215		686,215	(155,555)	530,660			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,978,759	789,168	3,033,954	6,801,881		6,801,881	(277,830)	6,536,195			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 Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	8,376	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,370)	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	(128,223)	30		9
10	Interest and Other Investment Income	(3,929)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,085)	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	(72,523)	43		18
19	Entertainment				19
20	Contributions	(500)	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		43		24
25	Fund Raising, Advertising and Promotional	(18,954)	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	(66,490)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (293,698)		$	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)	15,868	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 15,868		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (277,830)		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 Rehabilitation HCC

ID# 0052662

Report Period Beginning: 1/1/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (7,538)	43	1
2	X-Rays-Part A	(6,368)	43	2
3	Offset Transportation Revenue	(10,929)	11	3
4	Offset Vending Machine Income	(1,644)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(187)	21	5
6	Pet Expense	(720)	43	6
7	Disallowed Special Events	959	43	7
8	Disallowed Marketing Expense	(38,390)	43	8
9	Offset Miscellaneous Nursing Supplies	(392)	10	9
10	Offset Barber and Beauty Revenue	(1,215)	11	10
11			11	11
12			11	12
13	Disallowed Resident Flowers	(66)	43	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**	(66,490)		49

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care, Inc.	100.00%	$ 7,356	$ 7,356	1
2	V	2	Food		Petersen Health Care, Inc.	100.00%	176	176	2
3	V	3	Housekeeping		Petersen Health Care, Inc.	100.00%	38	38	3
4	V	5	Utilities		Petersen Health Care, Inc.	100.00%	496	496	4
5	V	6	Maintenance		Petersen Health Care, Inc.	100.00%	2,792	2,792	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care, Inc.	100.00%	60	60	7
8	V	10	Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2	2	8
9	V	10A	Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		10
11	V	17	Administrative		Petersen Health Care, Inc.	100.00%	0		11
12	V	19	Professional Services		Petersen Health Care, Inc.	100.00%	6,344	6,344	12
13	V								13
14	Total			$			$ 17,264	$ * 17,264	14

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 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)	
15	V	20	Dues, Fees, Subs & Promotions	$	Petersen Health Care, Inc.	100.00%	$ 353	$ 353	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	82,807	82,807	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care, Inc.	100.00%	3,765	3,765	17
18	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	42	42	18
19	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	26	26	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	6,697	6,697	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	1,180	1,180	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	6,763	6,763	23
24	V	32	Interest		Petersen Health Care, Inc.	100.00%	4,301	4,301	24
25	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	332	332	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	1,701	1,701	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			$			$ 107,967	$ * 107,967	39

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 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)	
15	V	1	Dietary	$	Petersen Health Network, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	5	Utilities		Petersen Health Network, LLC	100.00%	0		18
19	V	6	Maintenance		Petersen Health Network, LLC	100.00%	0		19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		20
21	V	9	Medical Director		Petersen Health Network, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	10A	Therapy		Petersen Health Network, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		24
25	V	17	Administrative		Petersen Health Network, LLC	100.00%	0		25
26	V	19	Professional Services		Petersen Health Network, LLC	100.00%	29,359	29,359	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	2,138	2,138	27
28	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%	387	387	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Network, LLC	100.00%	2,975	2,975	29
30	V	23	Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		30
31	V	24	Travel and Seminar		Petersen Health Network, LLC	100.00%	0		31
32	V	25	Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		34
35	V	30	Depreciation		Petersen Health Network, LLC	100.00%	993	993	35
36	V	31	Amortization of Pre-Op. & Org.		Petersen Health Network, LLC	100.00%	14,836	14,836	36
37	V	32	Interest		Petersen Health Network, LLC	100.00%	35,522	35,522	37
38	V	33	Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		38
39	Total			$			$ 86,210	$ * 86,210	39

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 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)	
15	V	1	Dietary	$	Petersen Health Care V, LLC	100.00%	$ 0	$	15
16	V	2	Food		Petersen Health Care V, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Care V, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Care V, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Care V, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Care V, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care V, LLC	100.00%	0		22
23	V	10A	Therapy		Petersen Health Care V, LLC	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		24
25	V	17	Administrative		Petersen Health Care V, LLC	100.00%	0		25
26	V	19	Professional Services		Petersen Health Care V, LLC	100.00%	3,030	3,030	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care V, LLC	100.00%	6,754	6,754	27
28	V	21	Clerical and General Office		Petersen Health Care V, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Care V, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Care V, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Care V, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care V, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Care V, LLC	100.00%	811	811	34
35	V	31	Amortization		Petersen Health Care V, LLC	100.00%	0		35
36	V	32	Interest		Petersen Health Care V, LLC	100.00%	21,040	21,040	36
37	V	34	Rent-Facility and Grounds		Petersen Health Care V, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care V, LLC	100.00%	0		38
39	Total			$			$ 31,635	$ * 31,635	39

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 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)	
15	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 9,533	$ 9,533	15
16	V	2	Food		Petersen Health Care Management, Inc.	100.00%	21	21	16
17	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	66	66	17
18	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	138	138	18
19	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	3,558	3,558	19
20	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		20
21	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	46	46	22
23	V	10A	TherUy		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		24
25	V	17	Administrative	475,400	Petersen Health Care Management, Inc.	100.00%	73,623	(401,777)	25
26	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	14,331	14,331	26
27	V	20	Dues, Fees, Subs & Promotions		Petersen Health Care Management, Inc.	100.00%	115	115	27
28	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	104,619	104,619	28
29	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	36,091	36,091	29
30	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	34	34	30
31	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	40	40	31
32	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	3,558	3,558	32
33	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	299	299	33
34	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		34
35	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	458	458	35
36	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	608	608	36
37	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	257	257	37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	797	797	38
39	Total			$ 475,400			$ 248,192	$ * (227,208)	39

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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, L	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 Syster	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care Y	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care Y	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach. MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health Ca	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	20
21			Flora Gardens Care Center	Flora	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	21
22			Flora Health Care Center	Flora	Petersen Health and W	Peoria	Mgmt/Bookkeeping	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 Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5			Cornerstone Health and Rehabilitation	Peoria				5
6			Rock River Gardens	Peoria				6
7			Sauk Valley Senior Living & Rehabilitation	Peoria				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 Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6	N/A										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 Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	1,572,338	77	$ 231,473	$ 220,289	49,968	$ 7,356	1
2	2	Food	Resident Days	1,572,338	77	5,537	0	49,968	176	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	0	49,968	38	3
4	5	Utilities	Resident Days	1,572,338	77	15,618	0	49,968	496	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	72,289	49,968	2,792	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	49,968	0	6
7	9	Medical Director	Resident Days	1,572,338	77	1,878	0	49,968	60	7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71	0	49,968	2	8
9	10A	TherUy	Resident Days	1,572,338	77	0	0	49,968	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	49,968	0	10
11	17	Administrative	Resident Days	1,572,338	77	0	0	49,968	0	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631	0	49,968	6,344	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115	0	49,968	353	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	2,406,945	49,968	82,807	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476	0	49,968	3,765	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316	0	49,968	42	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811	0	49,968	26	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720	0	49,968	6,697	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141	0	49,968	1,180	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77	0	0	49,968	0	20
21	30	Depreciation	Resident Days	1,572,338	77	212,800	0	49,968	6,763	21
22	32	Interest	Resident Days	1,572,338	77	135,328	0	49,968	4,301	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451	0	49,968	332	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540	0	49,968	1,701	24
25	TOTALS					$ 3,940,617	$ 2,699,523		$ 125,231	25

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 Network, LLC
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	247,554	14	$	$	49,968	$	1
2	2	Food	Resident Days	247,554	14			49,968		2
3	3	Housekeeping	Resident Days	247,554	14			49,968		3
4	5	Utilities	Resident Days	247,554	14			49,968		4
5	6	Maintenance	Resident Days	247,554	14			49,968		5
6	7	Mgmt. Allocation of Benefits	Resident Days	247,554	14			49,968		6
7	9	Medical Director	Resident Days	247,554	14			49,968		7
8	10	Nursing and Medical Records	Resident Days	247,554	14			49,968		8
9	10A	Therapy	Resident Days	247,554	14			49,968		9
10	15	Mgmt. Allocation of Benefits	Resident Days	247,554	14			49,968		10
11	17	Administrative	Resident Days	247,554	14			49,968		11
12	19	Professional Services	Resident Days	247,554	14	192,241		49,968	29,359	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	247,554	14	14,000		49,968	2,138	13
14	21	Clerical and General Office	Resident Days	247,554	14	2,534		49,968	387	14
15	22	Employee Benefits and Payroll Ta	Resident Days	247,554	14	19,477		49,968	2,975	15
16	23	Inservice Training & Education	Resident Days	247,554	14			49,968		16
17	24	Travel and Seminar	Resident Days	247,554	14			49,968		17
18	25	Other Admin. Staff Transport.	Resident Days	247,554	14			49,968		18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	247,554	14			49,968		19
20	27	Mgmt. Allocation of Benefits	Resident Days	247,554	14			49,968		20
21	30	Depreciation	Resident Days	247,554	14	6,500		49,968	993	21
22	31	Amortization of Pre-Op. & Org.	Resident Days	247,554	14	97,144		49,968	14,836	22
23	32	Interest	Resident Days	247,554	14	232,596		49,968	35,522	23
24	33	Real Estate Taxes	Resident Days	247,554	14			49,968		24
25	TOTALS					$ 564,492	$		$ 86,210	25

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 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

	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	16,881	77	$ 299,961	$	49,968	$	1
2	2	Food	Resident Days	16,881	77	675		49,968		2
3	3	Housekeeping	Resident Days	16,881	77	2,074		49,968		3
4	4	Laundry	Resident Days	16,881	77			49,968		4
5	5	Utilities	Resident Days	16,881	77	4,349		49,968		5
6	6	Maintenance	Resident Days	16,881	77	111,954		49,968		6
7	7	Mgmt. Allocation of Benefits	Resident Days	16,881	77			49,968		7
8	10	Nursing and Medical Records	Resident Days	16,881	77	1,457		49,968		8
9	10A	Therapy	Resident Days	16,881	77			49,968		9
10	15	Mgmt. Allocation of Benefits	Resident Days	16,881	77			49,968		10
11	17	Administrative	Resident Days	16,881	77			49,968		11
12	19	Professional Services	Resident Days	16,881	77	4,576,674		49,968	3,030	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	16,881	77	9,375		49,968	6,754	13
14	21	Clerical and General Office	Resident Days	16,881	77	450,944		49,968		14
15	23	Inservice Training & Education	Resident Days	16,881	77	3,292,039		49,968		15
16	24	Travel and Seminar	Resident Days	16,881	77	1,135,672		49,968		16
17	25	Other Admin. Staff Transport.	Resident Days	16,881	77	1,074		49,968		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	16,881	77	1,245		49,968		18
19	27	Mgmt. Allocation of Benefits	Resident Days	16,881	77	111,953		49,968		19
20	30	Depreciation	Resident Days	16,881	77	1,125		49,968	811	20
21	31	Amortization	Resident Days	16,881	77			49,968		21
22	32	Interest	Resident Days	16,881	77	14,419		49,968	21,040	22
23	34	Rent-Facility and Grounds	Resident Days	16,881	77	19,133		49,968		23
24	35	Rent-Equipment & Vehicles	Resident Days	16,881	77	8,076		49,968		24
25	TOTALS					$ 10,042,199	$		$ 31,635	25

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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 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 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	1,572,338	77	$ 231,473	$ 294,997	49,968	$ 9,533	1
2	2	Food	Resident Days	1,572,338	77	5,537		49,968	21	2
3	3	Housekeeping	Resident Days	1,572,338	77	1,187	558	49,968	66	3
4	5	Utilities	Resident Days	1,572,338	77	15,618		49,968	138	4
5	6	Maintenance	Resident Days	1,572,338	77	87,839	94,000	49,968	3,558	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			49,968		6
7	9	Medical Director	Resident Days	1,572,338	77	1,878		49,968		7
8	10	Nursing and Medical Records	Resident Days	1,572,338	77	71		49,968	46	8
9	10A	TherUy	Resident Days	1,572,338	77			49,968		9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			49,968		10
11	17	Administrative	Resident Days	1,572,338	77	4,576,674	4,576,674	49,968	73,623	11
12	19	Professional Services	Resident Days	1,572,338	77	199,631		49,968	14,331	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,572,338	77	11,115		49,968	115	13
14	21	Clerical and General Office	Resident Days	1,572,338	77	2,605,685	3,146,898	49,968	104,619	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,572,338	77	118,476		49,968	36,091	15
16	23	Inservice Training & Education	Resident Days	1,572,338	77	1,316		49,968	34	16
17	24	Travel and Seminar	Resident Days	1,572,338	77	811		49,968	40	17
18	25	Other Admin. Staff Transport.	Resident Days	1,572,338	77	210,720		49,968	3,558	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,572,338	77	37,141		49,968	299	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,572,338	77			49,968		20
21	30	Depreciation	Resident Days	1,572,338	77	212,800		49,968	458	21
22	32	Interest	Resident Days	1,572,338	77	135,328		49,968	608	22
23	33	Real Estate Taxes	Resident Days	1,572,338	77	10,451		49,968	257	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,572,338	77	53,540		49,968	797	24
25	TOTALS					$ 8,517,291	$ 8,113,127		$ 248,192	25

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	4/16/13	$ 6,512,605	$ 6,317,227	4/15/18	0.0404	$ 283,900	1
2												2
3												3
4												4
5												5
	Working Capital											
6								Interest Income Offset			(3,929)	6
7												7
8												8
9	TOTAL Facility Related						$ 6,512,605	$ 6,317,227			$ 279,971	9
	B. Non-Facility Related*											
10								Home Office Allocation-PHCM			608	10
11								Home Office Allocation-PHCV			21,040	11
12								Home Office Allocation-PHC			4,301	12
13								Home Office Allocation-PHN			35,522	13
14	TOTAL Non-Facility Related						$	$			$ 61,471	14
15	TOTALS (line 9+line14)						$ 6,512,605	$ 6,317,227			$ 341,442	15

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

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 142,440	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.)	2013	$ 143,868	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,428	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 148,188	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.	**Home Office Allocation**	589	
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 150,205	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	137,797	8
	2010	136,273	9
	2011	138,203	10
	2012	138,296	11
	2013	143,868	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marigold Rehabilitation HCC COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052662

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 2013 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 2013.

	(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	$ 143,867.62	$ 143,867.62
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 143,867.62	$ 143,867.62

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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.

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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: 561,304 2. Number of Years Over Which it is Being Amortized: 20

3. Current Period Amortization: 14,836 4. Dates Incurred: 2013-2014

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	46,584	2008	$ 583,785	1
2					2
3	TOTALS	46,584		$ 583,785	3

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	$ 727,454	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Generator Repair			2008	2,787		7	398	398	2,592	9
10	Water Heater			2008	7,200		5			7,200	10
11	Water Heater			2008	9,600		5			9,600	11
12	Sprinkler System Repair			2008	15,370		7	2,196	2,196	14,274	12
13	Roof Repair			2009	3,819		7	546	546	3,003	13
14	Parking Lot Resurfacing			2010	11,825		15	788	788	3,546	14
15	Sewer Line Repair			2010	4,338		7	620	620	2,790	15
16	Electrical Repair			2010	11,011		7	1,573	1,573	7,079	16
17	Out Building Removal and Filing of Dirt			2011	13,000		15	866	866	3,031	17
18	Painting of Wings #100 & #101			2011	5,548		15	370	370	1,295	18
19	Nurses Station Remodel			2011	14,531		15	968	968	3,388	19
20	Rooftop Unit			2011	11,391		15	760	760	2,660	20
21	Water Line Repair			2011	2,979		7	426	426	1,491	21
22	Fire Alarm Control System			2011	3,845		7	550	550	1,925	22
23	Sewer Line Repair			2012	2,599		7	372	372	930	23
24	Water Heater			2013	3,882		7	554	554	831	24
25	Carpentry, Drywall, and Flooring-Office Area			2014	21,663		15	1,444	1,444	2,527	25
26	Plumbing Repair			2014	6,504		7	929	929	1,626	26
27	Fixtures, Lamps, Lighting in Common Area			2014	17,788		15	1,186	1,186	1,976	27
28	Painting and Remodel-Dining Area, Library			2014	52,800		15	3,520	3,520	5,573	28
29	Painting and Remodel-Nurses Station, Office, Alzheimer's Unit			2014	11,475		15	765	765	1,211	29
30	Painting-West Wing 11 Rooms, 6 Bathrooms			2014	12,204		15	814	814	1,220	30
31	Plumbing for Rehab Reoom			2014	2,900		7	414	414	621	31
32	Painting-11 Rooms, 10 Bathrooms			2014	12,120		15	808	808	1,145	32
33	Painting and Remodel-West Wing			2014	12,165		15	811	811	1,081	33
34	Painiting and Tiling-Dining Room			2014	6,478		15	432	432	540	34
35	Therapy Room Repairs			2014	2,775		7	396	396	496	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 Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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	Land Improvements Booked			1,655			(1,655)		63
64	Building Booked			174,589			(174,589)		64
65	Building Improvement Booked			19,629			(19,629)		65
66									66
67	2014-Home Office Allocation-Building Improvements		23,325			559	559		67
68	2014-Home Office Allocation-Land Improvements		2,177			119	119		68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,672,823	$ 195,873		$ 135,100	$ (60,773)	$ 811,105	70

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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	$ 1,365,094	$ 76,196	$ 136,510	$ 60,314	5-10 yrs.	$ 769,720	71
72	Current Year Purchases	153,066	21,543	21,543		7 yrs.	34,020	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			8,347	8,347			74
75	TOTALS	$ 1,518,160	$ 97,739	$ 166,400	$ 68,661		$ 803,740	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	Facility	Van	2011	$ 83,600	$ 16,720	$ 16,720	$	5	$ 80,813	76
77	Facility	1997 Ford Passenger	2012	7,717	1,543	1,543		5	4,630	77
78	Facility	Vehicle	2013	4,235	847	847		5	2,047	78
79										79
80	TOTALS			$ 95,552	$ 19,110	$ 19,110	$		$ 87,490	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)	$ 6,870,320	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 312,722	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 320,610	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 7,888	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,702,335	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		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 62,338 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.

Marigold Rehabilitation HCC
0052662
Period Beginning **1/1/2014**
Period End **12/31/2014**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$ 48,007
Dishwasher	(394)
Laundry Equipment	112
Copier	12,115
Home Office Allocation	2,498
	62,338

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

   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.

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	14,407	$ 216,102	$	14,407	$ 216,102	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		3,831	57,461		3,831	57,461	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		13,976	209,638	37	13,976	209,675	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				130,542		130,542	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)			22	330		22	330	13
14	TOTAL			$	32,236	$ 483,531	$ 130,579	32,236	$ 614,110	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 Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/14 (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	$ 5,551,937	$ 5,551,937	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 131,644)	1,287,038	1,287,038	3
4	Supply Inventory (priced at Cost)	21,928	21,928	4
5	Short-Term Investments			5
6	Prepaid Insurance	62,228	62,228	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(640)	(640)	8
9	Other(specify): Prepaid Expenses	100,439	100,439	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 7,022,930	$ 7,022,930	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	608,610	583,785	13
14	Buildings, at Historical Cost	4,364,724	4,388,049	14
15	Leasehold Improvements, at Historical Cost	257,772	284,774	15
16	Equipment, at Historical Cost	1,611,442	1,613,712	16
17	Accumulated Depreciation (book methods)	(2,605,414)	(1,702,335)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,237,134	$ 5,167,985	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 11,260,064	$ 12,190,915	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 811,838	$ 811,838	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	193,205	193,205	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,930	37,930	31
32	Accrued Real Estate Taxes(Sch.IX-B)	148,188	148,188	32
33	Accrued Interest Payable	25,334	25,334	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	99,735	99,735	36
37	Accrued Management Fees	85,482	85,482	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,401,712	$ 1,401,712	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,317,227	6,317,227	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)**	$ 6,317,227	$ 6,317,227	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,718,939	$ 7,718,939	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,541,125	$ 4,471,976	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 11,260,064	$ 12,190,915	48

*(See instructions.)

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,605,223	1
2	Restatements (describe):		2
3	**Rounding**	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,605,229	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	935,896	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)**	$ 935,896	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)**	$ 3,541,125	24 *

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,388,933	1
2	Discounts and Allowances for all Levels	(864,128)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,524,805	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	872,197	6
7	Oxygen	3,556	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 875,753	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	1,215	13
14	Non-Patient Meals	8,376	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	280,900	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	17,246	20
21	Other Medical Services	12,401	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 320,138	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,929	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,929	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous & Vending Revenue	2,223	28
28a	Transportation Revenue	10,929	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,152	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,737,777	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,135,001	31
32	Health Care	3,066,946	32
33	General Administration	980,555	33
	B. Capital Expense		
34	Ownership	933,164	34
	C. Ancillary Expense		
35	Special Cost Centers	286,097	35
36	Provider Participation Fee	400,118	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,801,881	40
41	**Income before Income Taxes (line 30 minus line 40)****	935,896	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 935,896	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,573,389	44
45	Private Pay - Net Inpatient Revenue	1,340,708	45
46	Medicare - Net Inpatient Revenue	693,634	46
47	Other-(specify) Veterans -Net Patient Revenue		47
48	Other-(specify) Charity and Insurance Contractual Allowance	(82,926)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,524,805	49

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

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

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 69,812	$ 33.56	1
2	Assistant Director of Nursing	2,086	2,086	49,841	23.89	2
3	Registered Nurses	7,945	8,534	219,764	25.75	3
4	Licensed Practical Nurses	37,685	39,681	717,730	18.09	4
5	CNAs & Orderlies	84,614	89,322	990,874	11.09	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,891	5,271	58,758	11.15	10
11	Social Service Workers	3,905	4,241	78,042	18.40	11
12	Dietician					12
13	Food Service Supervisor	3,120	3,256	52,447	16.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,453	22,349	212,879	9.53	15
16	Dishwashers					16
17	Maintenance Workers	3,922	3,936	53,992	13.72	17
18	Housekeepers	16,843	17,296	164,531	9.51	18
19	Laundry	1,975	2,142	21,460	10.02	19
20	Administrator	2,080	2,080	75,180	36.14	20
21	Assistant Administrator	1,213	1,213	28,750	23.69	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,139	4,379	65,627	14.99	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 C: Alz. Coordinator					32
33	Other(specify) See PG20A	10,123	10,414	192,695	18.50	33
34	TOTAL (lines 1 - 33)	208,073	218,281	$ 3,052,381 *	$ 13.98	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	18,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,573	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	5	226	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)	5	$ 28,799		49

C. CONTRACT NURSES

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

Marigold Rehabilitation HCC
0052662
Period Beginning **1/1/2014**
Period End **12/31/2014**

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		4,751	4,759	107,889	22.67
Transportation		1,899	2,022	21,431	10.60
Alzheimer's Coordinator		1,913	2,074	30,021	14.48
Marketing		1,560	1,560	33,354	21.38
	TOTAL	10,123	10,414	192,695	

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Crystal Crain	Administrator	0	$ 73,623
Kendel Brooks	Asst. Adminstrator	0	18,750
Andrew Musser	Asst. Adminstrator	0	11,557
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,930

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 475,400
TOTAL (agree to Schedule V, line 17, col. 3)	$ 475,400
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
E-Health Data Solutions	Computer Services	$ 7,998
CenturyLink	Computer Services	1,378
Frontier Communications	Computer Services	80
Illinois Sec. of State	Filing Fees	130
Henry County Clerk	Filing Fees	60
HK Payroll Services	Payroll Services	5,172
Curaspan	Data Services	2,700
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 17,518

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 82,693
Unemployment Compensation Insurance	92,675
FICA Taxes	220,587
Employee Health Insurance	(189,117)
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	14,962
Employee Retirement	1,218
Home Office Allocation	42,831
TOTAL (agree to Schedule V, line 22, col.8)	$ 265,849

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	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	2,001
Miscellaneous Licenses & Permits	300
Miscellaneous Dues & Subscriptions	0
Home Office Allocation	9,360
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,651

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	66
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 66

**See instructions.

Marigold Rehabilitation HCC
0052662
Period Beginning **1/1/2014**
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Schedule 21A
XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		17,518
Home Office Allocation		
Lexis Nexis	Legal	17
GoffWilson	Legal	1,164
Illinois Secretary of State	Legal	105
Bank of America	Legal	352
Healthcare Resources International	Legal	211
Miscellaneous	Legal	45
Addy, Bush	Legal	30
Hall, Rustom, and Fritz	Legal	35
Black, Hedin, Ballard	Legal	61
SmithAmundsen	Legal	62
Applegate and Thorne	Legal	3,114
Healthcare Resources	Legal	1,883
ETS Environmental	Legal	171
IL Secretary of State	Legal	36
CliftonLarson Allen	Accountants	2,477
Ginoli & Co.	Accountants	11,589
Wells Fargo	Accountants	2,602
Miscellaneous	Computer Services	45
Odessian LLC	Computer Services	15
Optimizer	Computer Services	99
Allpayer Exchange	Computer Services	31
CCH	Computer Services	52
Prism Software	Computer Services	158
Macquarie Technology Services	Computer Services	138
Advanced Answers on Demand	Computer Services	7,340
Stratus Networks	Computer Services	967
Kemper Technology	Computer Services	2,863

AT&T	Computer Services	11
Ability Network	Computer Services	1,109
Barracuda	Computer Services	253
CIAN	Computer Services	302
Comcast	Computer Services	76
Emdeon	Computer Services	195
Charter Communications	Computer Services	12
E-Health Data Solutions	Computer Services	528
Crawford County Title Co.	Other Prof Fees	14
Better Banks	Other Prof Fees	9
David Budde	Other Prof Fees	85
All Scripts	Other Prof Fees	58
Miscellaneous	Other Prof Fees	9
Marotta Gund Budd Derza	Other Prof Fees	14,170
Polsinelli	Other Prof Fees	571
Total (agree to Schedule V, line 19, column 8)		70,582

Facility Name & ID Number Marigold Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					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 Rehabilitation HCC # 0052662 Report Period Beginning: 1/1/14 Ending: 12/31/14

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. **N/A**

(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. $ **33,894** 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. $ **400,118**
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. $ **8,376**

(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. $ **10,929**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **Adqequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(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. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.