FOR BHF USE

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2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 Rehab & Health Care Center

Address: 275 East 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 1/1/2017 to 12/31/2017 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 Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	34,418	9,687	2,839	46,944	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	34,418	9,687	2,839	46,944	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.78%

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

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
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 2,071

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	280,311	32,937		313,248		313,248	10,539	323,787			1
2	Food Purchase		295,694		295,694		295,694	(4,624)	291,070			2
3	Housekeeping	172,956	43,604		216,560		216,560	159	216,719			3
4	Laundry	21,585	22,012		43,597		43,597		43,597			4
5	Heat and Other Utilities			146,153	146,153		146,153	554	146,707			5
6	Maintenance	52,834	13,469	26,620	92,923		92,923	4,980	97,903			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	527,686	407,716	172,773	1,108,175		1,108,175	11,608	1,119,783			8
	B. Health Care and Programs											
9	Medical Director			63,750	63,750		63,750		63,750			9
10	Nursing and Medical Records	2,327,335	238,242	82,541	2,648,118		2,648,118	(578)	2,647,540			10
10a	Therapy			383,908	383,908		383,908		383,908			10a
11	Activities	124,701	9		124,710		124,710	(6,018)	118,692			11
12	Social Services	79,584			79,584		79,584		79,584			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	2,531,620	238,251	530,199	3,300,070		3,300,070	(6,596)	3,293,474			16
	C. General Administration											
17	Administrative			464,700	464,700		464,700	(381,200)	83,500			17
18	Directors Fees											18
19	Professional Services			21,870	21,870		21,870	60,927	82,797			19
20	Dues, Fees, Subscriptions & Promotions			9,520	9,520		9,520	146	9,666			20
21	Clerical & General Office Expenses	85,356	9,855	30,620	125,831		125,831	113,334	239,165			21
22	Employee Benefits & Payroll Taxes			360,629	360,629		360,629	51,018	411,647			22
23	Inservice Training & Education			984	984		984	315	1,299			23
24	Travel and Seminar							156	156			24
25	Other Admin. Staff Transportation			17,173	17,173		17,173	7,553	24,726			25
26	Insurance-Prop.Liab.Malpractice			54,055	54,055		54,055	2,001	56,056			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	85,356	9,855	959,551	1,054,762		1,054,762	(145,750)	909,012			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,144,662	655,822	1,662,523	5,463,007		5,463,007	(140,738)	5,322,269			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 Rehab & Health Care Center #0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			246,631	246,631		246,631	79,613	326,244			30
31	Amortization of Pre-Op. & Org.							23,741	23,741			31
32	Interest			319,705	319,705		319,705	45,422	365,127			32
33	Real Estate Taxes			165,913	165,913		165,913	605	166,518			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			102,419	102,419		102,419	3,202	105,621			35
36	Other (specify):*											36
37	**TOTAL Ownership**			834,668	834,668		834,668	152,583	987,251			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		86,195		86,195		86,195		86,195			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			361,760	361,760		361,760		361,760			42
43	Other (specify):*	39,578	487	303,356	343,421		343,421	(343,421)				43
44	**TOTAL Special Cost Centers**	39,578	86,682	665,116	791,376		791,376	(343,421)	447,955			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,184,240	742,504	3,162,307	7,089,051		7,089,051	(331,576)	6,757,475			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 # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,667)	2		4
5	Telephone, TV & Radio in Resident Rooms	(8,415)	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	52,537	30		9
10	Interest and Other Investment Income	(609)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(231)	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	(27,917)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(235,000)	43		24
25	Fund Raising, Advertising and Promotional	(12,745)	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	(68,047)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (303,094)		$	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)	(28,482)	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (28,482)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (331,576)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Marigold Rehab & Health Care Center

ID# 0052662

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (11,182)	43	1
2	X-Rays-Part A	(3,926)	43	2
3	Offset Transportation Revenue	(6,018)	11	3
4	Offset Vending Machine Income	(3,225)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(90)	21	5
6	Pet Expense	(789)	43	6
7	Disallowed Special Events	(927)	43	7
8	Disallowed Marketing Expense	(40,065)	43	8
9	Offset Miscellaneous Nursing Supplies	(724)	10	9
10	Vending Machine Expense	(1,001)	43	10
11	Disallowed Chamber of Commerce Dues	(100)	20	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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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**	(68,047)		49

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Management, Inc.	100.00%	$ 10,539	$ 10,539	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	45	45	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	159	159	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	554	554	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	4,980	4,980	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	146	146	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	464,700	Petersen Health Care Management, Inc.	100.00%	83,500	(381,200)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	33,004	33,004	12
13	V								13
14	Total			$ 464,700			$ 132,927	$ * (331,773)	14

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Management, Inc.	100.00%	$ 246	$ 246	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	113,424	113,424	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	51,018	51,018	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	315	315	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	156	156	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	7,553	7,553	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	2,001	2,001	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	27,011	27,011	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	243	243	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	878	878	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	605	605	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	3,202	3,202	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			$			$ 206,652	$ * 206,652	39

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	4	Laundry		Petersen Health Network, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Network, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Network, LLC	100.00%	0		20
21	V	7	Mgmt. Allocation of Benefits		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	15	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Network, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Network, LLC	100.00%	27,923	27,923	25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0		26
27	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%	0		27
28	V	22	Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0		28
29	V	23	Inservice Training & Education		Petersen Health Network, LLC	100.00%	0		29
30	V	24	Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0		31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	30	Depreciation		Petersen Health Network, LLC	100.00%	65	65	33
34	V	31	Amortization		Petersen Health Network, LLC	100.00%	23,498	23,498	34
35	V	32	Interest		Petersen Health Network, LLC	100.00%	45,153	45,153	35
36	V	33	Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0		38
39	Total			$			$ 96,639	$ * 96,639	39

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			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 Entert	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 Systen	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality LL	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care M	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busine	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care V	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care X	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Cornerstone Health and Rehabilitation	Peoria				1
2			Rock River Gardens	Sterling				2
3			Sauk Valley Senior Living & Rehabilitation	Rock Falls				3
4			Courtyard Estates of Farmington	Farmington				4
5			Courtyard Estates of Knoxville	Knoxville				5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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	1,451,714	75	$ 325,901	$ 376,129	46,944	$ 10,539	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	46,944	45	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	46,944	159	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	46,944	554	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	46,944	4,980	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	46,944	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	46,944	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	46,944	146	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	46,944	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	46,944	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	46,944	83,500	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	46,944	33,004	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	46,944	246	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	46,944	113,424	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	46,944	51,018	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	46,944	315	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	46,944	156	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	46,944	7,553	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	46,944	2,001	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	46,944	27,011	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	46,944	243	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	46,944	878	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	46,944	605	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	46,944	3,202	24
25	TOTALS					$ 12,790,903	$ 11,700,485		$ 339,579	25

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

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	241,133	13	$	$	46,944	$	1
2	2	Food	Resident Days	241,133	13			46,944		2
3	3	Housekeeping	Resident Days	241,133	13			46,944		3
4	4	Laundry	Resident Days	241,133	13			46,944		4
5	5	Utilities	Resident Days	241,133	13			46,944		5
6	6	Maintenance	Resident Days	241,133	13			46,944		6
7	7	Mgmt. Allocation of Benefits	Resident Days	241,133	13			46,944		7
8	10	Nursing and Medical Records	Resident Days	241,133	13			46,944		8
9	15	Mgmt. Allocation of Benefits	Resident Days	241,133	13			46,944		9
10	17	Administrative	Resident Days	241,133	13			46,944		10
11	19	Professional Services	Resident Days	241,133	13	143,430		46,944	27,923	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	241,133	13			46,944		12
13	21	Clerical and General Office	Resident Days	241,133	13			46,944		13
14	22	Employee Benefits & Payroll	Resident Days	241,133	13			46,944		14
15	23	Inservice Training & Education	Resident Days	241,133	13			46,944		15
16	24	Travel and Seminar	Resident Days	241,133	13			46,944		16
17	25	Other Admin. Staff Transport.	Resident Days	241,133	13			46,944		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	241,133	13			46,944		18
19	30	Depreciation	Resident Days	241,133	13	333		46,944	65	19
20	31	Amortization	Resident Days	241,133	13	120,698		46,944	23,498	20
21	32	Interest	Resident Days	241,133	13	231,932		46,944	45,153	21
22	33	Real Estate Taxes	Resident Days	241,133	13			46,944		22
23	34	Rent-Facility and Grounds	Resident Days	241,133	13			46,944		23
24	35	Rent-Equipment & Vehicles	Resident Days	241,133	13			46,944		24
25	TOTALS					$ 496,393	$		$ 96,639	25

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Wells Fargo		X	Mortgage	Varies	1/1/2015	$ 6,512,605	$ 5,535,714	12/31/34	Varies	$ 319,705	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,512,605	$ 5,535,714			$ 319,705	9
	B. Non-Facility Related*											
10								Interest Income Offset			(609)	10
11								Home Office Allocation-PHN			45,153	11
12								Home Office Allocation-PHCM			878	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 45,422	14
15	TOTALS (line 9+line14)						$ 6,512,605	$ 5,535,714			$ 365,127	15

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

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

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

Facility Name & ID Number Marigold Rehab & Health Care Center **#** 0052662 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	155,568	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.)	$	158,365	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,797	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	$	163,116	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**		605	
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.	$	166,518	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012	138,296	8
2013	143,868	9
2014	147,087	10
2015	151,035	11
2016	158,365	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marigold Rehab & Health Care Center COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0052662

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 158,364.56	$ 158,364.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 158,364.56	$ 158,364.56

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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? [X] YES [ ] 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: 23,741 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 Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 34,053	$ 1,063,202	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Generator Repair			2008	2,787		7			2,787	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			15,370	12
13	Roof Repair			2009	3,818		7			3,818	13
14	Parking Lot Resurfacing			2010	11,825		15	788	788	5,910	14
15	Sewer Line Repair			2010	4,338		7	308	308	4,338	15
16	Electrical Repair			2010	11,011		7	786	786	11,011	16
17	Out Building Removal and Filing of Dirt			2011	13,000		15	866	866	5,629	17
18	Painting of Wings #100 & #101			2011	5,548		15	370	370	2,405	18
19	Nurses Station Remodel			2011	14,531		15	968	968	6,292	19
20	Rooftop Unit			2011	11,391		15	760	760	4,940	20
21	Water Line Repair			2011	2,979		7	426	426	2,769	21
22	Fire Alarm Control System			2011	3,845		7	550	550	3,575	22
23	Sewer Line Repair			2012	2,599		7	372	372	2,046	23
24	Water Heater			2013	3,882		7	554	554	2,493	24
25	Carpentry, Drywall, and Flooring-Office Area			2014	21,663		15	1,444	1,444	5,054	25
26	Water Leak Repair on Water Main, Washer, Hot Water Heater			2014	6,504		7	929	929	3,252	26
27	Fixtures, Lamps, Lighting in Common Area			2014	17,788		15	1,186	1,186	4,151	27
28	Painting and Drywall for Walls in Dining Area, Library			2014	52,800		15	3,520	3,520	12,320	28
29	Painting, Drywall, Fans-Nurses Station, Office, Alzheimer's Unit			2014	11,475		15	765	765	2,678	29
30	Painting-West Wing 11 Rooms, 6 Bathrooms			2014	12,204		15	814	814	2,849	30
31	Plumbing for Rehab Room			2014	2,900		7	414	414	1,449	31
32	Painting-11 Rooms, 10 Bathrooms			2014	12,120		15	808	808	2,828	32
33	Painting and Remodel-11 Rooms and 6 Bathrooms in West Wing			2014	12,165		15	811	811	2,839	33
34	Painiting and Tiling-Dining Room			2014	6,478		15	432	432	1,512	34
35	Drywall and Flooring Repair-New Therapy Room			2014	2,775		7	396	396	1,386	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 # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	Fire Alarm Control Repair	2015	$ 11,173	$	7	$ 1,596	$ 1,596	$ 3,990	37
38	Heat Pump-Therapy Room	2015	6,469		15	432	432	1,080	38
39	Nurses Station Replacement	2015	31,309		15	2,088	2,088	5,220	39
40	Roof Replacement-North Portion	2015	14,930		25	598	598	1,495	40
41	Air Conditioner	2015	3,595		15	240	240	600	41
42	Landscaping	2015	16,398		7	2,344	2,344	5,860	42
43	Roof Repair	2016	17,178		7	2,454	2,454	3,681	43
44	Flooring for Hallways	2016	2,608		7	372	372	558	44
45	Water Heater	2017	11,383		7	813	813	813	45
46	Water Softeners	2017	10,288		7	735	735	735	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	Land Improvements Booked			1,655			(1,655)		64
65	Building Booked			174,589			(174,589)		65
66	Building Improvement Booked			27,950			(27,950)		66
67									67
68	2017-Home Office Allocation-Building Improvements		21,473			515	515		68
69	2017-Home Office Allocation-Land Improvements		1,976			128	128		69
70	TOTAL (lines 4 thru 69)		$ 4,796,100	$ 204,194		$ 142,498	$ (139,559)	$ 1,217,735	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 # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 1,542,558	$ 39,643	$ 154,500	$ 114,857	5-10 yrs.	$ 1,238,495	71
72	Current Year Purchases	5,917	404	423	19	7 yrs.	423	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			26,433	26,433			74
75	TOTALS	$ 1,548,475	$ 40,047	$ 181,356	$ 141,309		$ 1,238,918	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	$	$	$	5 yrs.	$ 83,600	76
77	Facility	1997 Ford Passenger	2012	7,717	1,543	1,543		5 yrs.	6,944	77
78	Facility	Vehicle	2013	4,234	847	847		5 yrs.	3,812	78
79										79
80	TOTALS			$ 95,551	$ 2,390	$ 2,390	$		$ 94,356	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)	$ 7,023,911	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 246,631	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 326,244	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 79,613	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,551,009	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					88
89	N/A				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 Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 105,621 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 Rehab & Health Care Center
0052662
Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	97,191
Dishwasher		701
Floor Scrubber		17
Copier		4,510
Home Office Allocation		3,202
		105,621

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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 Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$	11,379	$ 170,681	$	11,379	$ 170,681	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,666	24,987		1,666	24,987	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		12,549	188,240		12,549	188,240	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				86,195		86,195	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$	25,594	$ 383,908	$ 86,195	25,594	$ 470,103	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 # 0052662 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2017 (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	$ 5,577,053	$ 5,577,053	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 303,037)	2,994,391	2,994,391	3
4	Supply Inventory (priced at Cost)	21,928	21,928	4
5	Short-Term Investments			5
6	Prepaid Insurance	37,415	37,415	6
7	Other Prepaid Expenses	1,319	1,319	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,632,106	$ 8,632,106	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	4,386,197	14
15	Leasehold Improvements, at Historical Cost	383,102	409,903	15
16	Equipment, at Historical Cost	1,644,026	1,644,026	16
17	Accumulated Depreciation (book methods)	(3,424,008)	(2,551,009)	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)**	$ 3,576,454	$ 4,472,902	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,208,560	$ 13,105,008	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,124,687	$ 1,124,687	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	190,263	190,263	30
31	Accrued Taxes Payable (excluding real estate taxes)	305,408	305,408	31
32	Accrued Real Estate Taxes(Sch.IX-B)	163,116	163,116	32
33	Accrued Interest Payable	27,951	27,951	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	77,949	77,949	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,889,374	$ 1,889,374	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	5,535,714	5,535,714	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)**	$ 5,535,714	$ 5,535,714	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,425,088	$ 7,425,088	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,783,472	$ 5,679,920	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,208,560	$ 13,105,008	48

***(See instructions.)**

Facility Name & ID Number Marigold Rehab & Health Care Center **#** 0052662 **Report Period Beginning:** 1/1/2017 **Ending:** 12/31/2017

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,558,219	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**	17,163	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,575,382	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	208,090	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)**	$ 208,090	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)**	$ 4,783,472	24 *

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	$ 6,800,396	1
2	Discounts and Allowances for all Levels	(477,954)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,322,442	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	708,134	6
7	Oxygen	14,179	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 722,313	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	808	13
14	Non-Patient Meals	5,892	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	188,903	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	11,247	20
21	Other Medical Services	37,924	21
22	Laundry	171	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 244,945	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	609	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 609	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	6,018	28
28a	Miscellaneous Revenue	814	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,832	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,297,141	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,108,175	31
32	Health Care	3,300,070	32
33	General Administration	1,054,762	33
	B. Capital Expense		
34	Ownership	834,668	34
	C. Ancillary Expense		
35	Special Cost Centers	429,616	35
36	Provider Participation Fee	361,760	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,089,051	40
41	**Income before Income Taxes (line 30 minus line 40)****	208,090	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 208,090	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,339,867	44
45	Private Pay - Net Inpatient Revenue	1,474,025	45
46	Medicare - Net Inpatient Revenue	349,078	46
47	Other-(specify) Insurance Net Inpatient Revenue	159,472	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 6,322,442	49

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ 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 Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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	2,681	2,681	$ 72,487	$ 27.04	1
2	Assistant Director of Nursing	1,395	1,395	33,066	23.70	2
3	Registered Nurses	11,622	12,284	347,739	28.31	3
4	Licensed Practical Nurses	33,191	34,481	667,998	19.37	4
5	CNAs & Orderlies	81,420	83,454	1,087,938	13.04	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,725	8,725	80,903	9.27	10
11	Social Service Workers	4,537	5,034	79,584	15.81	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,056	36,630	17.82	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,254	23,185	243,681	10.51	15
16	Dishwashers					16
17	Maintenance Workers	4,123	4,259	52,834	12.41	17
18	Housekeepers	17,692	18,137	172,956	9.54	18
19	Laundry	1,829	1,949	21,585	11.07	19
20	Administrator	2,080	2,080	83,500	40.14	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	4,229	4,399	85,356	19.40	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,040	1,040	15,344	14.75	31
32	Other Health Care(specify)					32
33	Other(specify) See PG20A	8,295	8,645	186,139	21.53	33
34	TOTAL (lines 1 - 33)	207,169	213,804	$ 3,267,740 *	$ 15.28	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	63,750	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	12,253	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	Monthly	20,489	L10A, 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)		$ 96,492		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	376	$ 12,435	L10, C3	50
51	Licensed Practical Nurses	75	1,260	L10, C3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	451	$ 13,695		53

Marigold Rehab & Health Care Center
0052662
Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	2,930	3,106	101,926	32.82
Alzheimer's Coordinator	40	40	837	20.93
Transportation	3,380	3,388	43,798	12.93
Marketing	1,945	2,111	39,578	18.75
TOTAL	8,295	8,645	186,139	

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ethel Logue	Administrator	0	$ 83,500
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,500

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 464,700
TOTAL (agree to Schedule V, line 17, col. 3)	$ 464,700
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Computer Services	$ 9,396
Sorling Northrup	Legal Services	46
HK Payroll Services	Payroll Services	4,390
Comcast	Computer Services	1,683
Wells Fargo	Legal Services	93
SB2	Legal Services	6,262
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 21,870

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,287
Unemployment Compensation Insurance	53,814
FICA Taxes	239,041
Employee Health Insurance	1,456
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	4,205
Employee Retirement	1,826
Home Office Allocation	51,018
TOTAL (agree to Schedule V, line 22, col.8)	$ 411,647

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

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	2,754
Health Care Worker Background Check	
(Indicate # of checks performed 430)	3,169
Miscellaneous Licenses & Permits	555
Miscellaneous Dues & Subscriptions	1,052
Home Office Allocation	246
Less: Public Relations Expense	(100)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,666

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	156
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 156

* Attach copy of IMRF notifications

**See instructions.

Marigold Rehab & Health Care Center
0052662
Period Beginning **1/1/2017**
Period End **12/31/2017**

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	**Type**	**Amount**
Total (agree to Schedule V, line 19, column 3)		21,870
Home Office Allocation		
MusilloUnkenholt, LLC	Legal	376
Arnstein & Lehr	Legal	2535
SB2	Legal	1593
Miscellaneous	Legal	29
Miller Hall and Triggs	Legal	403
Smith Amundsen	Legal	157
Healthcare Resources International	Legal	279
Hunziker Law	Legal	2
Lexis Nexis	Legal	16
Baker Tilly Virchow Krause	Legal	1414
Secretary of State	Legal	341
Wells Fargo	Legal	664
CliftonLarsonAllen	Accounting	4529
Ginoli & Co.	Accounting	6490
Baker Tilly Virchow Krause	Accounting	282
Wells Fargo	Accounting	1849
Miscellaneous	Computer Services	214
Change Healthcare	Computer Services	18
360 Networks	Computer Services	87
Matrix Care	Computer Services	7898
Stratus Networks	Computer Services	943
Kemper Technology	Computer Services	535
AT&T	Computer Services	14
Ability Network	Computer Services	582
CIAN	Computer Services	657
Comcast	Computer Services	37
CCH	Computer Services	32
Charter Communications	Computer Services	66
Allscripts	Computer Services	585
ATS	Computer Services	601
Citrix Systems	Computer Services	55
Optimizer	Other Prof Fees	106
Ankura	Other Prof Fees	1700
David Budde	Other Prof Fees	79
Sargent Consulting	Other Prof Fees	24194
Alix Partners	Other Prof Fees	1149
Demonica Kemper	Other Prof Fees	70
Brad Barkley	Other Prof Fees	278
MPAC Healthcare	Other Prof Fees	42
Higgs Appraisal	Other Prof Fees	19
Alan Litwiller	Other Prof Fees	7
Total (agree to Schedule V, line 19, column 8)		82,797

Facility Name & ID Number Marigold Rehab & Health Care Center # 0052662 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-$952**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **38,602** Line **10**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **361,760**
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. $ **2,667**

(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. $ **6,018**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli and Company**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **No**
Attach invoices and a summary of services for all architect and appraisal fees