		FOR BHF USE					

LL1

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

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

I. IDPH License ID Number: 0055772

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

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	35,879	5,311	2,585	43,775	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	35,879	5,311	2,585	43,775	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.73%

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 1,752

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	287,282	28,972		316,254		316,254	11,656	327,910			1
2	Food Purchase		297,084		297,084		297,084	(6,572)	290,512			2
3	Housekeeping	184,417	38,957		223,374		223,374	225	223,599			3
4	Laundry	24,763	17,655		42,418		42,418		42,418			4
5	Heat and Other Utilities			124,064	124,064		124,064	796	124,860			5
6	Maintenance	59,286	15,086	45,928	120,300		120,300	7,000	127,300			6
7	Other (specify):*											7
8	TOTAL General Services	555,748	397,754	169,992	1,123,494		1,123,494	13,105	1,136,599			8
	B. Health Care and Programs											
9	Medical Director			54,000	54,000		54,000		54,000			9
10	Nursing and Medical Records	2,335,466	203,861	423,973	2,963,300		2,963,300	9,459	2,972,759			10
10a	Therapy			229,508	229,508		229,508		229,508			10a
11	Activities	90,275	9	100	90,384		90,384	(4,425)	85,959			11
12	Social Services	66,007			66,007		66,007		66,007			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,491,748	203,870	707,581	3,403,199		3,403,199	5,034	3,408,233			16
	C. General Administration											
17	Administrative	88,006		400,900	488,906		488,906	(336,078)	152,828			17
18	Directors Fees											18
19	Professional Services			11,456	11,456		11,456	38,289	49,745			19
20	Dues, Fees, Subscriptions & Promotions			5,859	5,859		5,859	5,967	11,826			20
21	Clerical & General Office Expenses	106,371	6,776	30,391	143,538		143,538	72,227	215,765			21
22	Employee Benefits & Payroll Taxes			336,892	336,892		336,892	19,840	356,732			22
23	Inservice Training & Education							120	120			23
24	Travel and Seminar							37	37			24
25	Other Admin. Staff Transportation			10,379	10,379		10,379	8,350	18,729			25
26	Insurance-Prop.Liab.Malpractice			84,173	84,173		84,173	4,101	88,274			26
27	Other (specify):*											27
28	TOTAL General Administration	194,377	6,776	880,050	1,081,203		1,081,203	(187,147)	894,056			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,241,873	608,400	1,757,623	5,607,896		5,607,896	(169,008)	5,438,888			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 #0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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			6,183	6,183		6,183	207,780	213,963			30
31	Amortization of Pre-Op. & Org.							76,488	76,488			31
32	Interest			915	915		915	339,445	340,360			32
33	Real Estate Taxes							165,791	165,791			33
34	Rent-Facility & Grounds			547,582	547,582		547,582	(547,582)				34
35	Rent-Equipment & Vehicles			43,989	43,989		43,989	4,232	48,221			35
36	Other (specify):*											36
37	TOTAL Ownership			598,669	598,669		598,669	246,154	844,823			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,934		81,934		81,934		81,934			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			285,482	285,482		285,482		285,482			42
43	Other (specify):*	82,722	589	100,919	184,230		184,230	(184,230)				43
44	TOTAL Special Cost Centers	82,722	82,523	386,401	551,646		551,646	(184,230)	367,416			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,324,595	690,923	2,742,693	6,758,211		6,758,211	(107,084)	6,651,127			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 # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	(3,405)	2		4
5	Telephone, TV & Radio in Resident Rooms	(9,166)	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	(42,065)	30		9
10	Interest and Other Investment Income	(96)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(298)	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	(40,683)	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	(39,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,245)	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	(102,438)	Various		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (238,896)		$	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)	131,812	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 131,812		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,084)		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

Marigold Rehabilitation HCC
ID# 0055772
Report Period Beginning: 1/1/2020
Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Labs-Part A	$ (8,582)	43	1
2	X-Rays-Part A	(1,438)	43	2
3	Offset Transportation Revenue	(4,425)	11	3
4	Offset Vending Machine Income	(3,167)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(45)	21	5
6	Pet Expense	(398)	43	6
7	Disallowed Special Events	(198)	43	7
8	Disallowed Marketing Expense	(82,722)	43	8
9	Offset Miscellaneous Nursing Supplies	(1,463)	10	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
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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**	(102,438)		49

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	$	Petersen Health Care Management, Inc.	100.00%	$ 11,656	$ 11,656	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	0		2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	225	225	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	796	796	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	7,000	7,000	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%	10,922	10,922	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	400,900	Petersen Health Care Management, Inc.	100.00%	64,822	(336,078)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	38,289	38,289	12
13	V								13
14	Total			$ 400,900			$ 133,710	$ * (267,190)	14

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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%	$ 5,967	$ 5,967	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	72,272	72,272	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	19,840	19,840	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	120	120	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	37	37	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	8,350	8,350	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	1,273	1,273	21
22	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	11,799	11,799	22
23	V	31	Amortization		Petersen Health Care Management, Inc.	100.00%	0		23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	575	575	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	459	459	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	4,232	4,232	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			$			$ 124,924	$ * 124,924	39

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	6	Maintenance	$	Marigold Land, LLC	100.00%	$	$	15
16	V	19	Professional Services	$	Marigold Land, LLC	100.00%			16
17	V	21	Equipment		Marigold Land, LLC	100.00%			17
18	V	26	Insurance-Property		Marigold Land, LLC	100.00%	2,828	2,828	18
19	V	26	Insurance-Mortgage Insurance		Marigold Land, LLC	100.00%			19
20	V	30	Depreciation		Marigold Land, LLC	100.00%	238,046	238,046	20
21	V	31	Amortization		Marigold Land, LLC	100.00%	76,488	76,488	21
22	V	32	Interest		Marigold Land, LLC	100.00%	338,966	338,966	22
23	V	33	Real Estate Taxes		Marigold Land, LLC	100.00%	165,332	165,332	23
24	V	34	Rent-Income and Grounds	547,582	Marigold Land, LLC	100.00%		(547,582)	24
25	V								25
26	V								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			$ 547,582			$ 821,660	$ * 274,078	39

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health 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 Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care '	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care)	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Quali	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 Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

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

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

	1	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	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,282,791	75	$ 341,562	$ 398,718	43,775	$ 11,656	1
2	2	Food	Resident Days	1,282,791	75	0	0	43,775	0	2
3	3	Housekeeping	Resident Days	1,282,791	75	6,607	3,056	43,775	225	3
4	5	Utilities	Resident Days	1,282,791	75	23,320	0	43,775	796	4
5	6	Maintenance	Resident Days	1,282,791	75	205,132	187,746	43,775	7,000	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	43,775	0	6
7	9	Medical Director	Resident Days	1,282,791	75	0	0	43,775	0	7
8	10	Nursing and Medical Records	Resident Days	1,282,791	75	320,057	736,064	43,775	10,922	8
9	10A	Therapy	Resident Days	1,282,791	75	0	0	43,775	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,282,791	75	0	0	43,775	0	10
11	17	Administrative	Resident Days	1,282,791	75	1,899,565	7,673,667	43,775	64,822	11
12	19	Professional Services	Resident Days	1,282,791	75	1,122,028	0	43,775	38,289	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,282,791	75	174,863	0	43,775	5,967	13
14	21	Clerical and General Office	Resident Days	1,282,791	75	2,117,880	2,195,755	43,775	72,272	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,282,791	75	581,393	0	43,775	19,840	15
16	23	Inservice Training & Education	Resident Days	1,282,791	75	3,513	0	43,775	120	16
17	24	Travel and Seminar	Resident Days	1,282,791	75	1,094	0	43,775	37	17
18	25	Other Admin. Staff Transport.	Resident Days	1,282,791	75	244,700	0	43,775	8,350	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,282,791	75	37,297	0	43,775	1,273	19
20	30	Depreciation	Resident Days	1,282,791	75	345,756	0	43,775	11,799	20
21	31	Amortization	Resident Days	1,282,791	75	0	0	43,775	0	21
22	32	Interest	Resident Days	1,282,791	75	16,842	0	43,775	575	22
23	33	Real Estate Taxes	Resident Days	1,282,791	75	13,451	0	43,775	459	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,282,791	75	124,017	0	43,775	4,232	24
25	TOTALS					$ 7,579,077	$ 11,195,006		$ 258,634	25

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	X-Caliber		X	Mortgage	Varies	12/1/19	4,663,073	$ 4,663,073	11/30/2029	Varies	$ 338,966	1
2	Dodge		X	Auto Loan	Varies	5/26/20	48,780	44,310	5/25/20	Varies	915	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 4,711,853	$ 4,707,383			$ 339,881	9
	B. Non-Facility Related*											
10								Interest Income Offset			(96)	10
11								Home Office Allocation-PHCM			575	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 479	14
15	TOTALS (line 9+line14)						$ 4,711,853	$ 4,707,383			$ 340,360	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 Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 159,432	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.)		$ 159,980	2
3. Under or (over) accrual (line 2 minus line 1).		$ 548	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 164,784	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**		459	
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.		$ 165,791	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	151,035	8
	2016	158,365	9
	2017	156,093	10
	2018	154,789	11
	2019	159,980	12

Accrual based on prior year tax bill.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	95-34-477-004	Long-Term Care Facility	$ 159,980.40	$ 159,980.40
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 159,980.40	$ 159,980.40

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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: 152,977 2. Number of Years Over Which it is Being Amortized: 2

3. Current Period Amortization: 76,488 4. Dates Incurred: 2020

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 # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 1,398,950	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	8,274	14
15	Sewer Line Repair			2010	4,338		7			4,338	15
16	Electrical Repair			2010	11,011		7			11,011	16
17	Out Building Removal and Filing of Dirt			2011	13,000		15	866	866	8,227	17
18	Painting of Wings #100 & #101			2011	5,548		15	370	370	3,515	18
19	Nurses Station Remodel			2011	14,531		15	968	968	9,196	19
20	Rooftop Unit			2011	11,391		15	760	760	7,220	20
21	Water Line Repair			2011	2,979		7			2,979	21
22	Fire Alarm Control System			2011	3,845		7			3,845	22
23	Sewer Line Repair			2012	2,599		7			2,599	23
24	Water Heater			2013	3,882		7	281	281	3,882	24
25	Carpentry, Drywall, and Flooring-Office Area			2014	21,663		15	1,444	1,444	9,386	25
26	Water Leak Repair on Water Main, Washer, Hot Water Heater			2014	6,504		7	929	929	6,039	26
27	Fixtures, Lamps, Lighting in Common Area			2014	17,788		15	1,186	1,186	7,709	27
28	Painting and Drywall for Walls in Dining Area, Library			2014	52,800		15	3,520	3,520	22,880	28
29	Painting, Drywall, Fans-Nurses Station, Office, Alzheimer's Unit			2014	11,475		15	765	765	4,973	29
30	Painting-West Wing 11 Rooms, 6 Bathrooms			2014	12,204		15	814	814	5,291	30
31	Plumbing for Rehab Room			2014	2,900		7	414	414	2,691	31
32	Painting-11 Rooms, 10 Bathrooms			2014	12,120		15	808	808	5,252	32
33	Painting and Remodel-11 Rooms and 6 Bathrooms in West Wing			2014	12,165		15	811	811	5,272	33
34	Painiting and Tiling-Dining Room			2014	6,478		15	432	432	2,808	34
35	Drywall and Flooring Repair-New Therapy Room			2014	2,775		7	396	396	2,574	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 # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

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

	1 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	$ 8,778	37
38	Heat Pump-Therapy Room	2015	6,469		15	432	432	2,376	38
39	Nurses Station Replacement	2015	31,309		15	2,088	2,088	11,484	39
40	Roof Replacement-North Portion	2015	14,930		25	598	598	3,289	40
41	Air Conditioner	2015	3,595		15	240	240	1,320	41
42	Landscaping	2015	16,398		7	2,344	2,344	12,892	42
43	Roof Repair	2016	17,178		7	2,454	2,454	11,043	43
44	Flooring for Hallways	2016	2,608		7	372	372	1,674	44
45	Water Heater	2017	11,383		7	1,626	1,626	5,691	45
46	Water Softeners	2017	10,288		7	1,470	1,470	5,145	46
47	Rooftop Unit	2019	13,000		15	866	866	1,299	47
48	Tree Removal and Grinding	2019	5,000		7	714	714	1,071	48
49	Air Conditioner Repair	2019	2,706		7	386	386	579	49
50	Compressor Repair	2019	3,249		7	464	464	696	50
51									51
52									52
53									53
54									54
55									55
56									56
57	Land Improvements Booked			8,613			(8,613)		57
58	Building Booked			174,589			(174,589)		58
59	Building Improvement Booked			33,353			(33,353)		59
60									60
61	2020-Home Office Allocation-Building Improvements		22,133			531	531		61
62	2020-Home Office Allocation-Land Improvements		2,220			141	141		62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,820,959	$ 216,555		$ 143,790	$ (72,765)	$ 1,645,023	70

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

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	$ 682,898	$ 17,113	$ 53,765	$ 36,652	5-10 yrs.	$ 583,800	71
72	Current Year Purchases	5,636	805	403	(402)	7 yrs.	403	72
73	Fully Depreciated Assets	889,336					889,336	73
74	Home Office Allocation			11,127	11,127			74
75	TOTALS	$ 1,577,870	$ 17,918	$ 65,295	$ 47,377		$ 1,473,539	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	$	$	$		$ 83,600	76
77	Facility	1997 Ford Passenger	2012	7,717					7,717	77
78	Facility	Vehicle	2013	4,234					4,234	78
79	Facility	2018 Dodge Pro	2020	48,780	9,756	4,878	(4,878)	5 yrs.	4,878	79
80	TOTALS			$ 144,331	$ 9,756	$ 4,878	$ (4,878)		$ 100,429	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)	$ 7,126,945	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 244,229	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 213,963	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (30,266)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,218,991	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			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 # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 48,221 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.

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Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	$	37,746
Dishwasher		1,403
Copier		4,840
Home Office Allocation		4,232
		48,221

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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.

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	$	6,860	$ 102,897	$	6,860	$ 102,897	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,835	27,532		1,835	27,532	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,605	99,079		6,605	99,079	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				81,934		81,934	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			$	15,300	$ 229,508	$ 81,934	15,300	$ 311,442	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (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	$ 154,320	$ 154,320	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 37,747)	4,403,142	4,403,142	3
4	Supply Inventory (priced at Cost)	21,928	21,928	4
5	Short-Term Investments			5
6	Prepaid Insurance	35,444	38,272	6
7	Other Prepaid Expenses		51,860	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,614,834	$ 4,669,522	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		583,785	13
14	Buildings, at Historical Cost		4,386,857	14
15	Leasehold Improvements, at Historical Cost		434,102	15
16	Equipment, at Historical Cost	149,967	1,722,201	16
17	Accumulated Depreciation (book methods)	(101,734)	(3,218,991)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		152,977	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(89,236)	20
21	Restricted Funds		247,120	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Loans	3,198,981	3,147,121	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,247,214	$ 7,365,936	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,862,048	$ 12,035,458	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 820,398	$ 859,973	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,234	157,234	30
31	Accrued Taxes Payable (excluding real estate taxes)	186,997	186,997	31
32	Accrued Real Estate Taxes(Sch.IX-B)		164,784	32
33	Accrued Interest Payable		28,710	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	188,298	188,298	36
37	Accrued Management Fees	70,762	70,762	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,423,689	$ 1,656,758	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	44,310	44,310	39
40	Mortgage Payable		4,663,073	40
41	Bonds Payable			41
42	Deferred Compensation	416,315	416,315	42
	Other Long-Term Liabilities(specify):			
43	Loan Payable-MCAD Adv. Payment	760,000	760,000	43
44	Loan Payable-SBA PPP	725,500	725,500	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,946,125	$ 6,609,198	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,369,814	$ 8,265,956	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,492,234	$ 3,769,502	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,862,048	$ 12,035,458	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 70,990	1
2	Restatements (describe):		2
3	**Adjustments Made After Cost Reports Were Filed**	2,216,668	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,287,658	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,204,576	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)**	$ 2,204,576	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)**	$ 4,492,234	24 *

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

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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	$ 8,513,893	1
2	Discounts and Allowances for all Levels	(1,114,665)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,399,228	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	463,164	6
7	Oxygen	1,501	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 464,665	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	251	13
14	Non-Patient Meals	6,572	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	107,783	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,755	20
21	Other Medical Services	20,499	21
22	Laundry	121	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 144,981	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	96	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 96	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation Revenue	4,425	28
28a	Miscellaneous and COVID Stimulus Revenue	949,392	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 953,817	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,962,787	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,123,494	31
32	Health Care	3,403,199	32
33	General Administration	1,081,203	33
	B. Capital Expense		
34	Ownership	598,669	34
	C. Ancillary Expense		
35	Special Cost Centers	266,164	35
36	Provider Participation Fee	285,482	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,758,211	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,204,576	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,204,576	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 5,261,267	44
45	Private Pay - Net Inpatient Revenue	1,088,025	45
46	Medicare - Net Inpatient Revenue	656,654	46
47	Other-(specify) Insurance Net Inpatient Revenue	393,282	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,399,228	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 # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

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	505	505	$ 21,493	$ 42.56	1
2	Assistant Director of Nursing	1,248	1,248	33,583	26.91	2
3	Registered Nurses	11,053	11,593	373,639	32.23	3
4	Licensed Practical Nurses	30,322	31,076	829,432	26.69	4
5	CNAs & Orderlies	59,668	61,421	916,808	14.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,005	1,076	19,178	17.82	9
10	Activity Assistants	4,844	5,055	53,089	10.50	10
11	Social Service Workers	3,593	3,781	66,007	17.46	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	39,940	19.20	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,175	21,873	247,342	11.31	15
16	Dishwashers					16
17	Maintenance Workers	4,234	4,360	59,286	13.60	17
18	Housekeepers	16,067	16,232	184,417	11.36	18
19	Laundry	1,947	2,032	24,763	12.19	19
20	Administrator	2,355	2,419	88,006	36.38	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,951	2,105	42,229	20.06	23
24	Clerical	4,301	4,614	64,142	13.90	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	20	20	425	21.25	31
32	Other Health Care(specify)					32
33	Other(specify) Page 20A	10,023	10,301	260,816	25.32	33
34	TOTAL (lines 1 - 33)	176,391	181,791	$ 3,324,595 *	$ 18.29	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	54,000	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	13,295	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	60	3,680	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)	60	$ 70,975		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	13,726	406,998	L10,C3	52
53	TOTAL (lines 50 - 52)	13,726	$ 406,998		53

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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	4,318	4,584	149,834	32.69
Transportation	1,563	1,575	18,008	11.43
Alzheimer's Coordinator	338	338	10,252	30.33
Marketing	3,804	3,804	82,722	21.75
TOTAL	10,023	10,301	260,816	

Facility Name & ID Number Marigold Rehabilitation HCC # 0055772 Report Period Beginning: 1/1/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Ethel Logue	Administrator	0	$ 88,006
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,006

B. Administrative - Other

Description	Amount
Management Fees-See Page 6, Eliminated on P 3, C 7	$ 400,900
TOTAL (agree to Schedule V, line 17, col. 3)	$ 400,900
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ability Network	Computer Services	$ 7,168
CliftonLarson Allen	Accounting Fees	1,155
Livingston, Barger, Brandt	Legal Fees-1/20/20	333
Comcast	Computer Services	1,300
RASI Entity Staffing	Professional Fees	1,500
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 11,456

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,649
Unemployment Compensation Insurance	28,519
FICA Taxes	243,147
Employee Health Insurance	1,612
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Relations	2,665
Home Office Allocation	19,840
Employee Retirement	1,696
Administrator Benefits	17,604
TOTAL (agree to Schedule V, line 22, col.8)	$ 356,732

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	$ 1,554
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 23)	
Patient Background Checks 123	3,707
Miscellaneous Licenses & Permits	598
Home Office Allocation	5,967
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,826

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Home Office Allocation	37
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 37

* Attach copy of IMRF notifications

**See instructions.

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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)		11,456
Home Office Allocation		
Baker Tilly Virchow Krause LLP	Legal	674
Duane Morris	Legal	942
Lexis Nexis	Legal	18
Livingston, Barger, Brant, Schroeder	Legal	36
Miller, Hall, Triggs	Legal	116
Miscellaneous	Legal	43
SB2	Legal	348
SmithAmundsen LLC	Legal	2,154
Sorling Northrup	Legal	614
CliftonLarsonAllen	Accounting	2,676
Ginoli & Co.	Accounting	1,910
Ability Network	Computer Services	6,871
Allscripts	Computer Services	1,085
AOD Matrix Care	Computer Services	12,068
AT&T	Computer Services	13
ATS	Computer Services	658
CCH	Computer Services	38
Charter Communications	Computer Services	61
Citrix Systems	Computer Services	205
Comcast	Computer Services	70
ITSavvy	Computer Services	318
Kemper Technology	Computer Services	1,568
Miscellaneous	Computer Services	304
Pearl Technology	Computer Services	284
Stratus Networks	Computer Services	1,246
TR Professional	Computer Services	27
David Budde	Other Prof Fees	28
DJ Howard and Associates	Other Prof Fees	52
Getzler Henrich & Associates	Other Prof Fees	212
LRI Consulting Services	Other Prof Fees	207
McQuellon Consulting	Other Prof Fees	131
Miscellaneous	Other Prof Fees	249
Optimizer	Other Prof Fees	112
Registered Agent Solutions	Other Prof Fees	62
RSM McGladrey	Other Prof Fees	682
SB2	Other Prof Fees	871
Sedgwick CMS	Other Prof Fees	1,174
Tarver Program Consultants	Other Prof Fees	162
Total (agree to Schedule V, line 19, column 8)		49,745

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Schedule 21B

25. Administrative and Staff Transportation

Gas	$	3,792
Auto Repairs		6,052
Mileage-Travel		535
Home Office Allocation		8,350
		18,729

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XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

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

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

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

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **42,927** 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. $ **285,482**
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. $ **3,405**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **4,425**
c. What percent of all travel expense relates to transportation of nurses and patients? **100**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.