

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148 Report Period Beginning: 2/1/2008 Ending: 12/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>172</u>	Skilled (SNF)	<u>172</u>	<u>57,620</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>172</u>	TOTALS	<u>172</u>	<u>57,620</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>24,366</u>	<u>5,516</u>	<u>5,199</u>	<u>35,081</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,366</u>	<u>5,516</u>	<u>5,199</u>	<u>35,081</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.88%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES

NO

Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

NO

I. On what date did you start providing long term care at this location?

Date started 02/01/2008

J. Was the facility purchased or leased after January 1, 1978?

YES

Date 02/01/2008

NO

K. Was the facility certified for Medicare during the reporting year?

YES

NO

If YES, enter number of beds certified 170 and days of care provided 4,943

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL

MODIFIED

CASH*

CASH*

Is your fiscal year identical to your tax year?

YES NO

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 2/1/2008 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	209,725	25,945		235,670		235,670	6,236	241,906		1
2	Food Purchase		192,869		192,869		192,869	(8,621)	184,248		2
3	Housekeeping	46,843	113,174		160,017		160,017	46	160,063		3
4	Laundry	10,628	65,509		76,137		76,137	3	76,140		4
5	Heat and Other Utilities			147,380	147,380		147,380	646	148,026		5
6	Maintenance	43,142	8,087	35,194	86,423		86,423	3,811	90,234		6
7	Other (specify):* Home Off. Ben. All.							1,533	1,533		7
8	TOTAL General Services	310,338	405,584	182,574	898,496		898,496	3,654	902,150		8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000		12,000		12,000		9
10	Nursing and Medical Records	1,683,984	140,289	3,014	1,827,287		1,827,287	10,793	1,838,080		10
10a	Therapy	40,443	723	450,091	491,257		491,257		491,257		10a
11	Activities	62,169	861	1,540	64,570		64,570		64,570		11
12	Social Services	57,332			57,332		57,332		57,332		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Home Off. Ben. All.							1,889	1,889		15
16	TOTAL Health Care and Programs	1,843,928	141,873	466,645	2,452,446		2,452,446	12,682	2,465,128		16
	C. General Administration										
17	Administrative	96,756		136,000	232,756		232,756	(87,459)	145,297		17
18	Directors Fees										18
19	Professional Services			12,384	12,384		12,384	6,383	18,767		19
20	Dues, Fees, Subscriptions & Promotions			3,621	3,621		3,621	1,238	4,859		20
21	Clerical & General Office Expenses	27,064	17,604	25,541	70,209		70,209	63,625	133,834		21
22	Employee Benefits & Payroll Taxes			345,641	345,641		345,641		345,641		22
23	Inservice Training & Education			1,541	1,541		1,541	370	1,911		23
24	Travel and Seminar			1,165	1,165		1,165	371	1,536		24
25	Other Admin. Staff Transportation			6,757	6,757		6,757	4,796	11,553		25
26	Insurance-Prop.Liab.Malpractice			29,709	29,709		29,709	292	30,001		26
27	Other (specify):* Home Off. Ben. All.							17,342	17,342		27
28	TOTAL General Administration	123,820	17,604	562,359	703,783		703,783	6,958	710,741		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,278,086	565,061	1,211,578	4,054,725		4,054,725	23,294	4,078,019		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

#0049148

Report Period Beginning:

2/1/2008

Ending:

12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			278,332	278,332		278,332	(167,776)	110,556			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			288,494	288,494		288,494	16,302	304,796			32
33	Real Estate Taxes			128,700	128,700		128,700	890	129,590			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			24,106	24,106		24,106	759	24,865			35
36	Other (specify):*											36
37	TOTAL Ownership			719,632	719,632		719,632	(149,825)	569,807			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		175,307		175,307		175,307		175,307			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,430	86,430		86,430		86,430			42
43	Other (specify):* Non-allowable cost	73,373	791	186,008	260,172		260,172	(260,172)				43
44	TOTAL Special Cost Centers	73,373	176,098	272,438	521,909		521,909	(260,172)	261,737			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,351,459	741,159	2,203,648	5,296,266		5,296,266	(386,703)	4,909,563			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,723)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(174,413)	30		9
10	Interest and Other Investment Income	(3,240)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(429)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,011)	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	(150,475)	43		24
25	Fund Raising, Advertising and Promotional	(97,516)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(11,352)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (447,159)		\$	30

BHF USE ONLY							
48		49		50		51	

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	2	
		Amount	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)	60,456	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 60,456		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (386,703)		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	2	3	4	
		Yes	No	Amount	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 Rehab & Health Care Center

ID# 0049148

Report Period Beginning: 2/1/2008

Ending: 12/31/08

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (7,730)	43	1
2	X-Rays-Part A	(1,675)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(29)	10	3
4	Resident Flowers	(242)	43	4
5	Offset Miscellaneous Office Supplies Revenue	(130)	21	5
6	Offset Chamber of Commerce Dues	(452)	20	6
7	Pet Expense	(1,094)	43	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
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(11,352)		49

Facility Name & ID Number

Marigold Rehab & Health Care Center

0049148

Report Period Beginning:

2/1/2008

Ending:

12/31/08

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 6,236	\$ 6,236	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	102	102	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	46	46	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	3	3	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	646	646	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,811	3,811	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,533	1,533	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	10,822	10,822	8
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,889	1,889	10
11	V	17 Administrative	136,000	Petersen Health Care, Inc.	100.00%	48,541	(87,459)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	5,479	5,479	12
13	V							13
14	Total		\$ 136,000			\$ 79,108	\$ * (56,892)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 1,690	\$	1,690	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	60,915		60,915	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	370		370	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	371		371	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	4,796		4,796	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	292		292	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	17,342		17,342	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	6,637		6,637	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	4,668		4,668	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	890		890	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	759		759	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		\$			\$ 98,730	\$ *	98,730	39

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

Facility Name & ID Number Marigold Rehab & Health Care Center# 0049148Report Period Beginning: 2/1/2008Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 Dietary	\$	Petersen Health Care VI, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care VI, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care VI, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care VI, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care VI, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care VI, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care VI, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care VI, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Health Care VI, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care VI, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Health Care VI, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Health Care VI, LLC	100.00%	904	904	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care VI, LLC	100.00%	0		27	
28	V	21 Clerical and General Office		Petersen Health Care VI, LLC	100.00%	2,840	2,840	28	
29	V	23 Inservice Training & Education		Petersen Health Care VI, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care VI, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care VI, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care VI, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care VI, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care VI, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Care VI, LLC	100.00%	14,874	14,874	35	
36	V	33 Real Estate Taxes		Petersen Health Care VI, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care VI, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care VI, LLC	100.00%	0		38	
39	Total		\$			\$ 18,618	\$ *	18,618	39

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 2/1/2008 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	***	1.46	2.43	Salary	***	L17, C7	1
2											2
3											3
4											4
5			***Other Nursing Home Compensation and Compensation are								5
6			Attached on Schedule 7A								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

0049148

Report Period Beginning:

2/1/2008

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,413,604	69	\$ 251,260	\$ 250,687	35,081	\$ 6,236	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	35,081	102	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	35,081	46	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	35,081	3	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	35,081	646	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	35,081	3,811	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	35,081	1,533	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	35,081	10,822	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	35,081	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	35,081	1,889	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	35,081	48,541	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	35,081	5,479	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	35,081	1,690	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	35,081	60,915	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	35,081	370	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	35,081	371	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	35,081	4,796	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	35,081	292	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	35,081	17,342	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	35,081	6,637	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	35,081	4,668	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	35,081	890	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	35,081	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	35,081	759	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 177,838	25

Facility Name & ID Number Marigold Rehab & Health Care Center# 0049148

Report Period Beginning:

2/1/2008Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization

Petersen Health Care VI, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	51,992	2	\$	35,081	\$	1
2	2	Food	Resident Days	51,992	2		35,081		2
3	3	Housekeeping	Resident Days	51,992	2		35,081		3
4	4	Laundry	Resident Days	51,992	2		35,081		4
5	5	Utilities	Resident Days	51,992	2		35,081		5
6	6	Maintenance	Resident Days	51,992	2		35,081		6
7	7	Mgmt. Allocation of Benefits	Resident Days	51,992	2		35,081		7
8	10	Nursing and Medical Records	Resident Days	51,992	2		35,081		8
9	10A	Therapy	Resident Days	51,992	2		35,081		9
10	15	Mgmt. Allocation of Benefits	Resident Days	51,992	2		35,081		10
11	17	Administrative	Resident Days	51,992	2		35,081		11
12	19	Professional Services	Resident Days	51,992	2	1,340	35,081	904	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	51,992	2		35,081		13
14	21	Clerical and General Office	Resident Days	51,992	2	4,209	35,081	2,840	14
15	23	Inservice Training & Education	Resident Days	51,992	2		35,081		15
16	24	Travel and Seminar	Resident Days	51,992	2		35,081		16
17	25	Other Admin. Staff Transport.	Resident Days	51,992	2		35,081		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	51,992	2		35,081		18
19	27	Mgmt. Allocation of Benefits	Resident Days	51,992	2		35,081		19
20	30	Depreciation	Resident Days	51,992	2		35,081		20
21	32	Interest	Resident Days	51,992	2	22,044	35,081	14,874	21
22	33	Real Estate Taxes	Resident Days	51,992	2		35,081		22
23	34	Rent-Facility and Grounds	Resident Days	51,992	2		35,081		23
24	35	Rent-Equipment & Vehicles	Resident Days	51,992	2		35,081		24
25	TOTALS					\$ 27,593	\$	\$ 18,618	25

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 2/1/2008 Ending: 12/31/08

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	The Private Bank		X	Mortgage	Varies	4/15/08	\$ 4,554,000	\$ 4,495,993	4/15/13	0.0404	\$ 277,689	1								
2												2								
3							Interest Income Offset				(3,240)	3								
4							Home Office Allocation-PHC				4,668	4								
5							Home Office Allocation-PHC VI				14,874	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related						\$ 4,554,000	\$ 4,495,993			\$ 293,991	9								
B. Non-Facility Related*																				
10							Amortization of Loan Costs				10,805	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 10,805	14								
15	TOTALS (line 9+line14)						\$ 4,554,000	\$ 4,495,993			\$ 304,796	15								

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

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.		\$	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.)		\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	128,700 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			890
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.		\$	129,590 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	8
	2004	9
	2005	10
	2006	11
	2007	12

Accrual based on the purchase price of the facility times the county tax rate.

This facility was owned by a not-for-profit entity and therefore has not paid real estate taxes prior to this cost report

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Marigold Rehab & Health Care Center COUNTY Knox

FACILITY IDPH LICENSE NUMBER 0049148

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	<u>N/A</u>	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

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 & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,654 B. General Construction Type: Exterior Brick and Block Frame Wood Number of Stories 1

C. Does the Operating Entity? (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? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>46,584</u>	<u>2008</u>	<u>\$ 583,785</u>	<u>1</u>
2					<u>2</u>
3	TOTALS	46,584		\$ 583,785	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	172	2008	1971	\$ 4,364,724	\$	39	\$ 55,958	\$ 55,958	\$ 55,958	4
5										5
6										6
7	Home Office Allocation									7
8										8
Improvement Type**										
9	Generator Repair		2008	2,787		7	200	200	200	9
10	Water Heater		2008	7,200		5	720	720	720	10
11	Water Heater		2008	9,600		5	960	960	960	11
12	Sprinkler System Repair		2008	15,370		7	1,098	1,098	1,098	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148

Report Period Beginning:

2/1/2008

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45			160,040			(160,040)		45
46			1,831			(1,831)		46
47								47
48								48
49		1,219			79	79		49
50		18,215			437	437		50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70		\$ 4,419,115	\$ 161,871		\$ 59,452	\$ (102,419)	\$ 58,936	70

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

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148

Report Period Beginning:

2/1/2008

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	<u>889,336</u>	<u>116,461</u>	<u>44,467</u>	<u>(71,994)</u>	<u>10 yrs.</u>	<u>44,467</u>	72
73	Fully Depreciated Assets							73
74	<u>Home Office Allocation</u>			<u>6,637</u>	<u>6,637</u>			74
75	TOTALS	\$ <u>889,336</u>	\$ <u>116,461</u>	\$ <u>51,104</u>	\$ <u>(65,357)</u>		\$ <u>44,467</u>	75

D. Vehicle Depreciation (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,892,236	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 278,332	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 110,556	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (167,776)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 103,403	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	<u>N/A</u>				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	<u>N/A</u>		93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. 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: _____ *

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: \$ 24,865 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			N/A		18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____ /2009 \$ _____

13. _____ /2010 \$ _____

14. _____ /2011 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Marigold Rehab & Health Care Center

0049148

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	17,953
Dishwasher	\$	877
Copier		5,276
Home Office Allocation		759
		<u>24,865</u>

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.)

	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	\$	13,420	\$ 201,271	\$	13,420	\$ 201,271	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		1,444	24,534		1,444	24,534	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs	40,443	14,931	223,966	723	14,931	265,132	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 prescripts				175,307		175,307	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): <u>Respiratory Therapy</u>				21	320		21	320	13
14	TOTAL			\$ 40,443	29,816	\$ 450,091	\$ 176,030	29,816	\$ 666,564	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 Rehab & Health Care Center

0049148

Report Period Beginning: 2/1/2008

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (1,484,428)	\$ (1,484,428)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 40,000)	1,401,107	1,401,107	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,784	42,784	6
7	Other Prepaid Expenses	30,223	30,223	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (10,314)	\$ (10,314)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	583,785	583,785	13
14	Buildings, at Historical Cost	4,364,724	4,382,939	14
15	Leasehold Improvements, at Historical Cost	34,957	36,176	15
16	Equipment, at Historical Cost	889,336	889,336	16
17	Accumulated Depreciation (book methods)	(278,332)	(103,403)	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 (spec <u>Loan Costs</u>)	61,228	61,228	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,655,698	\$ 5,850,061	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,645,384	\$ 5,839,747	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 711,694	\$ 711,694	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	183,014	183,014	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,555	5,555	31
32	Accrued Real Estate Taxes(Sch.IX-B)	128,700	128,700	32
33	Accrued Interest Payable	4,815	4,815	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	45,733	45,733	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,079,511	\$ 1,079,511	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,495,993	4,495,993	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>A/P-Other</u>	4,953	4,953	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,500,946	\$ 4,500,946	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,580,457	\$ 5,580,457	46
47	TOTAL EQUITY (page 18, line 24)	\$ 64,927	\$ 259,290	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,645,384	\$ 5,839,747	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	64,927	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)	\$ 64,927	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)	\$ 64,927	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,204,746	1
2	Discounts and Allowances for all Levels	269,155	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,473,901	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	594,845	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 594,845	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,766	13
14	Non-Patient Meals	5,829	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	264,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	7,796	20
21	Other Medical Services	5,537	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 285,400	23
	D. Non-Operating Revenue		
24	Contributions	754	24
25	Interest and Other Investment Income***	3,240	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 3,994	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	159	28
28a	Vending Maching Income	2,894	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,053	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,361,193	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	898,496	31
32	Health Care	2,452,446	32
33	General Administration	703,783	33
	B. Capital Expense		
34	Ownership	719,632	34
	C. Ancillary Expense		
35	Special Cost Centers	435,479	35
36	Provider Participation Fee	86,430	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,296,266	40
41	Income before Income Taxes (line 30 minus line 40)**	64,927	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 64,927	43

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

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

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

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

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148

Report Period Beginning: 2/1/2008

Ending: 12/31/08

12/31/08

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing		\$	\$	1
2	Assistant Director of Nursing				2
3	Registered Nurses				3
4	Licensed Practical Nurses	SEE ATTACHED SCH PG20A			4
5	CNAs & Orderlies				5
6	CNA Trainees				6
7	Licensed Therapist				7
8	Rehab/Therapy Aides				8
9	Activity Director				9
10	Activity Assistants				10
11	Social Service Workers				11
12	Dietician				12
13	Food Service Supervisor				13
14	Head Cook				14
15	Cook Helpers/Assistants				15
16	Dishwashers				16
17	Maintenance Workers				17
18	Housekeepers				18
19	Laundry				19
20	Administrator				20
21	Assistant Administrator				21
22	Other Administrative				22
23	Office Manager				23
24	Clerical				24
25	Vocational Instruction				25
26	Academic Instruction				26
27	Medical Director				27
28	Qualified MR Prof. (QMRP)				28
29	Resident Services Coordinator				29
30	Habilitation Aides (DD Homes)				30
31	Medical Records				31
32	Other Health Care(specify)				32
33	Other(specify)				33
34	TOTAL (lines 1 - 33)		\$ *	\$	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$		35
36	Medical Director	Monthly 12,000	9(3)	36
37	Medical Records Consultant	Monthly 1,080	10(3)	37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 1,100	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 14,180		49

C. CONTRACT NURSES

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

Marigold Rehab & Health Care Center

0049148

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 20A**XVIII. Staffing and Salary Costs**

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Director of Nursing	2,078	2,078	40,402	19.44
Assistant Director of Nsg.	1,914	1,914	35,854	18.73
Registered Nurses	8,386	8,592	163,484	19.03
Licensed Practical Nurses	33,489	35,621	549,471	15.43
Nurse Aides & Orderlies	69,279	72,961	775,155	10.62
Nurse Aide Trainees				
Licensed Therapist				
Activity Director	1,588	1,876	28,259	15.06
Activity Assistants	3,140	3,441	33,119	9.63
Social Service Workers	3,374	3,779	57,332	15.17
Dietician				
Food Service Supervisor	1,907	1,907	35,723	18.74
Head Cook				
Cook Helpers/Assistants	19,646	20,877	174,002	8.33
Dishwashers				
Maintenance Workers	3,281	3,795	43,142	11.37
Housekeepers	5,705	5,705	46,843	8.21
Laundry	1,276	1,276	10,628	8.33
Administrator	3,895	4,646	96,756	20.83
Assistant Administrator				
Other Administrative				
Office & Clerical	3,280	3,682	27,064	7.35
Marketing	4,052	4,052	71,581	17.67
Vocational Instruction				
Academic Instruction				
Medical Director				
Qualified Mental Retard.Prof.				
Resident Services Coordinator				
Habilitation Aides				
Medical Records	1,767	2,039	26,559	13.03
Physical Therapy Aide	3,122	3,549	42,542	11.99
Transportation	58	94	791	8.41
Care Plan Coordinator	3,450	3,626	66,500	18.34
Alzheimer's Coordinator	1,677	1,677	26,252	15.65
TOTAL (lines 1 - 35)	176,362	187,186	2,351,459	

Marigold Rehab & Health Care Center

0049148

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		12,384

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	199
GoffWilson, P.A.	Legal	665
Ginoli & Company	Accountants	2,520
RSM McGladrey	Accountants	15
Miscellaneous Vendors	Computer Services	79
Emdeon Business Services	Computer Services	107
Advanced Answers on Demand	Computer Services	1,259
Access 2 Go	Computer Services	371
Ivans	Computer Services	193
Kemper Technology	Computer Services	682
VisionShare	Computer Services	73
Logmein	Computer Services	52
Comm Net Communiations	Computer Services	19
Charter Communications	Computer Services	16
Advanced System Designs	Computer Services	24
Consolidated Communications	Computer Services	15
Miscellaneous Vendors	Miscellaneous	94

Total (agree to Schedule V, line 19, column 8)	<u>18,767</u>
--	---------------

Marigold Rehab & Health Care Center

0049148

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
JoAnn Azer	Administrator	0	24,218
Crystal Crain	Administrator	0	44,667
Vickie Hager	Administrator	0	27,871
	Total		<u>96,756</u>

Facility Name & ID Number Marigold Rehab & Health Care Center# 0049148Report Period Beginning: 2/1/2008Ending: 12/31/08**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? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,829 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? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 86,430
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 8,621
- (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? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees