

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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>62,780</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>62,780</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5 Total	
		3 Medicaid Recipient	3 Private Pay	4 Other	4 Total		
8	SNF	<u>25,613</u>	<u>6,692</u>	<u>8,136</u>	<u>40,441</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>25,613</u>	<u>6,692</u>	<u>8,136</u>	<u>40,441</u>		14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.42%

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 1/31/2008

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 172 and days of care provided 4,911

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	242,583	30,369		272,952		272,952	7,072	280,024		1
2	Food Purchase		220,706		220,706		220,706	(14,765)	205,941		2
3	Housekeeping	151,041	43,469		194,510		194,510	67	194,577		3
4	Laundry	30,778	24,642		55,420		55,420		55,420		4
5	Heat and Other Utilities			155,137	155,137		155,137	698	155,835		5
6	Maintenance	51,687	12,745	38,659	103,091		103,091	3,425	106,516		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							1,277	1,277		7
8	TOTAL General Services	476,089	331,931	193,796	1,001,816		1,001,816	(2,226)	999,590		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,966,596	160,948	19,140	2,146,684		2,146,684	4,060	2,150,744		10
10a	Therapy	35,814	281	624,100	660,195		660,195		660,195		10a
11	Activities	100,256	641	2,126	103,023		103,023		103,023		11
12	Social Services	67,319	11		67,330		67,330		67,330		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							527	527		15
16	TOTAL Health Care and Programs	2,169,985	161,881	663,366	2,995,232		2,995,232	4,587	2,999,819		16
	C. General Administration										
17	Administrative	26,564		490,000	516,564		516,564	(434,902)	81,662		17
18	Directors Fees										18
19	Professional Services			6,781	6,781		6,781	16,164	22,945		19
20	Dues, Fees, Subscriptions & Promotions			4,300	4,300		4,300	2,658	6,958		20
21	Clerical & General Office Expenses	62,137	23,306	20,516	105,959		105,959	78,634	184,593		21
22	Employee Benefits & Payroll Taxes			361,942	361,942		361,942		361,942		22
23	Inservice Training & Education			1,551	1,551		1,551	736	2,287		23
24	Travel and Seminar							227	227		24
25	Other Admin. Staff Transportation			7,715	7,715		7,715	3,554	11,269		25
26	Insurance-Prop.Liab.Malpractice			56,690	56,690		56,690	1,474	58,164		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							19,357	19,357		27
28	TOTAL General Administration	88,701	23,306	949,495	1,061,502		1,061,502	(312,098)	749,404		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,734,775	517,118	1,806,657	5,058,550		5,058,550	(309,737)	4,748,813		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:

1/1/2009

Ending:

12/31/2009

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			310,280	310,280		310,280	(101,826)	208,454			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			286,241	286,241		286,241	24,400	310,641			32
33	Real Estate Taxes			122,868	122,868		122,868	895	123,763			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			26,742	26,742		26,742	857	27,599			35
36	Other (specify):*											36
37	TOTAL Ownership			746,131	746,131		746,131	(75,674)	670,457			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		225,269		225,269		225,269		225,269			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			94,170	94,170		94,170		94,170			42
43	Other (specify):* Non-allowable Cost	17,450		252,655	270,105		270,105	(270,105)				43
44	TOTAL Special Cost Centers	17,450	225,269	346,825	589,544		589,544	(270,105)	319,439			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,752,225	742,387	2,899,613	6,394,225		6,394,225	(655,516)	5,738,709			45

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

Marigold Rehab & Health Care CenterID# 0049148Report Period Beginning: 1/1/2009Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (26,815)	43	1
2	X-Rays-Part A	(3,383)	43	2
3	Offset Miscellaneous Nursing Supplies Revenue	(220)	10	3
4	Offset Vending Machine Income	(3,831)	2	4
5	Offset Miscellaneous Office Supplies Revenue	(68)	21	5
6	Offset Chamber of Commerce Dues	(352)	20	6
7	Pet Expense	(1,114)	43	7
8	Disallowed Special Events	(2,424)	43	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	(38,207)		49

STATE OF ILLINOIS

Summary A

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	7,072	0	0	0	0	0	0	0	0	0	7,072	1
2	Food Purchase	(14,924)	159	0	0	0	0	0	0	0	0	0	(14,765)	2
3	Housekeeping	0	67	0	0	0	0	0	0	0	0	0	67	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	698	0	0	0	0	0	0	0	0	0	698	5
6	Maintenance	0	3,425	0	0	0	0	0	0	0	0	0	3,425	6
7	Other (specify):*	0	1,277	0	0	0	0	0	0	0	0	0	1,277	7
8	TOTAL General Services	(14,924)	12,698	0	0	0	0	0	0	0	0	0	(2,226)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(220)	4,280	0	0	0	0	0	0	0	0	0	4,060	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	527	0	0	0	0	0	0	0	0	0	527	15
16	TOTAL Health Care and Programs	(220)	4,807	0	0	0	0	0	0	0	0	0	4,587	16
	C. General Administration													
17	Administrative	0	(434,902)	0	0	0	0	0	0	0	0	0	(434,902)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	9,916	0	6,248	0	0	0	0	0	0	0	16,164	19
20	Fees, Subscriptions & Promotions	(352)	0	2,763	247	0	0	0	0	0	0	0	2,658	20
21	Clerical & General Office Expenses	(68)	0	72,114	6,588	0	0	0	0	0	0	0	78,634	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	736	0	0	0	0	0	0	0	0	736	23
24	Travel and Seminar	0	0	227	0	0	0	0	0	0	0	0	227	24
25	Other Admin. Staff Transportation	0	0	3,554	0	0	0	0	0	0	0	0	3,554	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,474	0	0	0	0	0	0	0	0	1,474	26
27	Other (specify):*	0	0	19,357	0	0	0	0	0	0	0	0	19,357	27
28	TOTAL General Administration	(420)	(424,986)	100,225	13,083	0	(312,098)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(15,564)	(407,481)	100,225	13,083	0	(309,737)	29						

STATE OF ILLINOIS

Summary B

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

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(107,655)	0	5,829	0	0	0	0	0	0	0	0	(101,826)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,572)	0	8,965	18,007	0	0	0	0	0	0	0	24,400	32
33	Real Estate Taxes	0	0	895	0	0	0	0	0	0	0	0	895	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	857	0	0	0	0	0	0	0	0	857	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(110,227)	0	16,546	18,007	0	(75,674)	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(270,105)	0	0	0	0	0	0	0	0	0	0	(270,105)	43
44	TOTAL Special Cost Centers	(270,105)	0	0	0	0	0	0	0	0	0	0	(270,105)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(395,896)	(407,481)	116,771	31,090	0	0	0	0	0	0	0	(655,516)	45

Facility Name & ID Number

Marigold Rehab & Health Care Center

0049148

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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%	\$ 7,072	\$ 7,072	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	159	159	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	67	67	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	0		4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	698	698	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	3,425	3,425	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	1,277	1,277	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,280	4,280	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%	527	527	10
11	V	17 Administrative	490,000	Petersen Health Care, Inc.	100.00%	55,098	(434,902)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	9,916	9,916	12
13	V							13
14	Total		\$ 490,000			\$ 82,519	\$ * (407,481)	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%	\$ 2,763	\$	2,763	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	72,114		72,114	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	736		736	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	227		227	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	3,554		3,554	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	1,474		1,474	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	19,357		19,357	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	5,829		5,829	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	8,965		8,965	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	895		895	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%	857		857	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		\$			\$ 116,771	\$ *	116,771	39

* 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	1 Dietary	\$	Petersen Health Care V, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Health Care V, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Health Care V, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Health Care V, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Health Care V, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Health Care V, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Health Care V, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Health Care V, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Health Care V, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Health Care V, LLC	100.00%	6,248	6,248	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Health Care V, LLC	100.00%	247	247	27	
28	V	21 Clerical and General Office		Petersen Health Care V, LLC	100.00%	6,588	6,588	28	
29	V	23 Inservice Training & Education		Petersen Health Care V, LLC	100.00%	0		29	
30	V	24 Travel and Seminar		Petersen Health Care V, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Health Care V, LLC	100.00%	0		31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care V, LLC	100.00%	0		32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Health Care V, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Health Care V, LLC	100.00%	0		34	
35	V	32 Interest		Petersen Health Care V, LLC	100.00%	18,007	18,007	35	
36	V	33 Real Estate Taxes		Petersen Health Care V, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Health Care V, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Health Care V, LLC	100.00%	0		38	
39	Total		\$			\$ 31,090	\$ *	31,090	39

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

Facility Name & ID Number Marigold Rehab & Health Care Center # 0049148 Report Period Beginning: 1/1/2009 Ending: 12/31/2009

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	154,515	1.58	2.63	Salary	\$ 4,598	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 4,598		13

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

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

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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

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

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

1	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	1,493,044	75	\$ 261,102	\$ 259,584	40,441	\$ 7,072	1
2	2	Food	Resident Days	1,493,044	75	5,864	0	40,441	159	2
3	3	Housekeeping	Resident Days	1,493,044	75	2,458	0	40,441	67	3
4	4	Laundry	Resident Days	1,493,044	75	0	0	40,441	0	4
5	5	Utilities	Resident Days	1,493,044	75	25,776	0	40,441	698	5
6	6	Maintenance	Resident Days	1,493,044	75	126,463	107,810	40,441	3,425	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	47,148	0	40,441	1,277	7
8	10	Nursing and Medical Records	Resident Days	1,493,044	75	158,020	151,697	40,441	4,280	8
9	10A	Therapy	Resident Days	1,493,044	75	0	0	40,441	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	19,462	0	40,441	527	10
11	17	Administrative	Resident Days	1,493,044	75	3,315,953	3,315,953	40,441	55,098	11
12	19	Professional Services	Resident Days	1,493,044	75	366,089	0	40,441	9,916	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,493,044	75	102,022	0	40,441	2,763	13
14	21	Clerical and General Office	Resident Days	1,493,044	75	2,662,394	2,253,243	40,441	72,114	14
15	23	Inservice Training & Education	Resident Days	1,493,044	75	27,176	0	40,441	736	15
16	24	Travel and Seminar	Resident Days	1,493,044	75	8,381	0	40,441	227	16
17	25	Other Admin. Staff Transport.	Resident Days	1,493,044	75	131,200	0	40,441	3,554	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,493,044	75	54,425	0	40,441	1,474	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,493,044	75	714,650	0	40,441	19,357	19
20	30	Depreciation	Resident Days	1,493,044	75	215,197	0	40,441	5,829	20
21	32	Interest	Resident Days	1,493,044	75	330,981	0	40,441	8,965	21
22	33	Real Estate Taxes	Resident Days	1,493,044	75	33,065	0	40,441	895	22
23	34	Rent-Facility and Grounds	Resident Days	1,493,044	75	0	0	40,441	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,493,044	75	31,635	0	40,441	857	24
25	TOTALS					\$ 8,639,461	\$ 6,088,287		\$ 199,290	25

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148

Report Period Beginning:

1/1/2009

Ending: 2/31/2009

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

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

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

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	58,530	2	\$	\$	40,441	\$	1
2	2	Food	Resident Days	58,530	2			40,441		2
3	3	Housekeeping	Resident Days	58,530	2			40,441		3
4	4	Laundry	Resident Days	58,530	2			40,441		4
5	5	Utilities	Resident Days	58,530	2			40,441		5
6	6	Maintenance	Resident Days	58,530	2			40,441		6
7	7	Mgmt. Allocation of Benefits	Resident Days	58,530	2			40,441		7
8	10	Nursing and Medical Records	Resident Days	58,530	2			40,441		8
9	10A	Therapy	Resident Days	58,530	2			40,441		9
10	15	Mgmt. Allocation of Benefits	Resident Days	58,530	2			40,441		10
11	17	Administrative	Resident Days	58,530	2			40,441		11
12	19	Professional Services	Resident Days	58,530	2	9,042		40,441	6,248	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	58,530	2	357		40,441	247	13
14	21	Clerical and General Office	Resident Days	58,530	2	9,535		40,441	6,588	14
15	23	Inservice Training & Education	Resident Days	58,530	2			40,441		15
16	24	Travel and Seminar	Resident Days	58,530	2			40,441		16
17	25	Other Admin. Staff Transport.	Resident Days	58,530	2			40,441		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	58,530	2			40,441		18
19	27	Mgmt. Allocation of Benefits	Resident Days	58,530	2			40,441		19
20	30	Depreciation	Resident Days	58,530	2			40,441		20
21	32	Interest	Resident Days	58,530	2	26,061		40,441	18,007	21
22	33	Real Estate Taxes	Resident Days	58,530	2			40,441		22
23	34	Rent-Facility and Grounds	Resident Days	58,530	2			40,441		23
24	35	Rent-Equipment & Vehicles	Resident Days	58,530	2			40,441		24
25	TOTALS					\$ 44,995	\$		\$ 31,090	25

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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										
										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	<u>The Private Bank</u>		<u>X</u>	<u>Mortgage</u>	<u>Varies</u>	<u>4/15/08</u>	<u>\$ 4,554,000</u>	<u>\$ 4,425,990</u>	<u>4/15/13</u>	<u>0.0404</u>	<u>\$ 271,834</u>	<u>1</u>							
2												<u>2</u>							
3							<u>Interest Income Offset</u>				<u>(2,572)</u>	<u>3</u>							
4							<u>Home Office Allocation-PHC</u>				<u>8,965</u>	<u>4</u>							
5							<u>Home Office Allocation-PHC V</u>				<u>18,007</u>	<u>5</u>							
Working Capital																			
6												<u>6</u>							
7												<u>7</u>							
8												<u>8</u>							
9	TOTAL Facility Related						<u>\$ 4,554,000</u>	<u>\$ 4,425,990</u>			<u>\$ 296,234</u>	<u>9</u>							
B. Non-Facility Related*																			
10							<u>Amortization of Loan Costs</u>				<u>14,407</u>	<u>10</u>							
11												<u>11</u>							
12												<u>12</u>							
13												<u>13</u>							
14	TOTAL Non-Facility Related						<u>\$</u>	<u>\$</u>			<u>\$ 14,407</u>	<u>14</u>							
15	TOTALS (line 9+line14)						<u>\$ 4,554,000</u>	<u>\$ 4,425,990</u>			<u>\$ 310,641</u>	<u>15</u>							

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.)

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? (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	\$ 111,916	\$ 111,916	\$ 167,874
5										
6										
7										
8										
	Improvement Type**									
9	Generator Repair		2008		2,787		7	400	400	600
10	Water Heater		2008		7,200		5	1,440	1,440	2,160
11	Water Heater		2008		9,600		5	1,920	1,920	2,880
12	Sprinkler System Repair		2008		15,370		7	2,196	2,196	3,294
13	Roof Repair		2009		3,819		7	273	273	273
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28	Building Booked					174,589			(174,589)	
29	Building Improvement Booked					6,318			(6,318)	
30										
31										
32	2009-Home Office Allocation-Land Improvements				1,330			84	84	
33	2009-Home Office Allocation-Building Improvements				19,881			477	477	
34										
35										
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

XI. OWNERSHIP COSTS (continued)

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

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

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

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148

Report Period Beginning:

1/1/2009

Ending:

12/31/2009

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	\$ 889,336	\$ 127,048	\$ 88,934	\$ (38,114)	10 yrs.	\$ 133,401	71
72	Current Year Purchases	16,277	2,325	814	(1,511)	10 yrs.	814	72
73	Fully Depreciated Assets							73
74	Home Office Allocation							74
75	TOTALS	\$ 905,613	\$ 129,373	\$ 89,748	\$ (39,625)		\$ 134,215	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)	\$ 5,914,109	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 310,280	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 208,454	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (101,826)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 311,296	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88	N/A				88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

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? YES NO

If NO, see instructions.

		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: \$ 27,599 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. _____ /2010 \$ _____

13. _____ /2011 \$ _____

14. _____ /2012 \$ _____

* 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 1/1/2009

Period End 12/31/2009

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	22,099
Dishwasher	\$	953
Copier		3,690
Home Office Allocation		857
		<u>27,599</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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	\$	18,459	\$ 276,886	\$	18,459	\$ 276,886	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,543	38,143		2,543	38,143	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2,3)	hrs		20,605	309,071	281	20,605	309,352	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				225,269		225,269	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>									13
14	TOTAL			\$	41,607	\$ 624,100	\$ 225,550	41,607	\$ 849,650	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/2009**

(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	\$ (563,556)	\$ (563,556)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>150,000</u>)	1,259,318	1,259,318	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	85,741	85,741	6
7	Other Prepaid Expenses	21,928	21,928	7
8	Accounts Receivable (owners or related parties)	(11,884)	(11,884)	8
9	Other(specify): <u>Employee Advances</u>	800	800	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 792,347	\$ 792,347	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	4,384,605	14
15	Leasehold Improvements, at Historical Cost	38,776	40,106	15
16	Equipment, at Historical Cost	905,613	905,613	16
17	Accumulated Depreciation (book methods)	(588,612)	(311,296)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe <u>Loan Costs</u>)	46,822	46,822	22
23	Other(specify): <u>A/R-Prior Owner</u>	22,905	22,905	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 5,374,013	\$ 5,672,540	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,166,360	\$ 6,464,887	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 926,016	\$ 926,016	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	186,311	186,311	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,215	3,215	31
32	Accrued Real Estate Taxes(Sch.IX-B)	128,700	128,700	32
33	Accrued Interest Payable	7,936	7,936	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Payroll Withholdings</u>	125,127	125,127	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,377,305	\$ 1,377,305	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable	4,425,990	4,425,990	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 4,425,990	\$ 4,425,990	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,803,295	\$ 5,803,295	46
47	TOTAL EQUITY(page 18, line 24)	\$ 363,065	\$ 661,592	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,166,360	\$ 6,464,887	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 64,927	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 64,928	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	298,137	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)	\$ 298,137	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)	\$ 363,065	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Marigold Rehab & Health Care Center

0049148

Report Period Beginning: 1/1/2009

Ending: 12/31/2009

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	\$ 5,472,725	1
2	Discounts and Allowances for all Levels	(61,930)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,410,795	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	843,658	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 843,658	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	1,970	13
14	Non-Patient Meals	11,093	14
15	Telephone, Television and Radio	33	15
16	Rental of Facility Space		16
17	Sale of Drugs	390,350	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	17,269	20
21	Other Medical Services	10,503	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 431,218	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,572	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,572	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Revenue	288	28
28a	Vending/Machining Income	3,831	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,119	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,692,362	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,001,816	31
32	Health Care	2,995,232	32
33	General Administration	1,061,502	33
B. Capital Expense			
34	Ownership	746,131	34
C. Ancillary Expense			
35	Special Cost Centers	495,374	35
36	Provider Participation Fee	94,170	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,394,225	40
41	Income before Income Taxes (line 30 minus line 40)**	298,137	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 298,137	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:

1/1/2009

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 53,041	\$ 25.50	1
2	Assistant Director of Nursing	2,127	2,127	48,601	22.85	2
3	Registered Nurses	5,597	5,887	141,762	24.08	3
4	Licensed Practical Nurses	38,863	40,153	677,469	16.87	4
5	CNAs & Orderlies	84,261	87,440	892,778	10.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,693	2,919	35,814	12.27	8
9	Activity Director	1,818	2,038	33,375	16.38	9
10	Activity Assistants	3,750	4,054	40,808	10.07	10
11	Social Service Workers	3829	4,172	67,319	16.14	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	46,048	22.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,876	22,580	196,535	8.70	15
16	Dishwashers					16
17	Maintenance Workers	3,879	4,095	51,687	12.62	17
18	Housekeepers	17,425	17,612	151,041	8.58	18
19	Laundry	3,615	3,735	30,778	8.24	19
20	Administrator	2,080	2,080	77,064	37.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	5,457	5,781	62,137	10.75	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	2,263	2,415	36,168	14.98	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Sch. 20A</u>	8,096	8,650	160,300	18.53	33
34	TOTAL (lines 1 - 33)	211,789	219,898	\$ 2,802,725 *	\$ 12.75	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	18,000	9(3)	36
37	Medical Records Consultant	Monthly	360	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,240	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)		\$ 19,600		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 1/1/2009

Period End 12/31/2009

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Marketing	520	520	17,450	33.56
Transportation	1,893	2,077	26,073	12.55
Care Plan Coordinator	3,723	4,008	82,384	20.55
Alzheimer's Coordinator	1,960	2,045	34,393	16.82
TOTAL (lines 1 - 35)	8,096	8,650	160,300	

Marigold Rehab & Health Care Center

0049148

Period Beginning 1/1/2009

Period End 12/31/2009

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		6,781

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	63
GoffWilson, P.A.	Legal	90
Jackson Lewis	Legal	711
Peter Gartelos	Legal	69
Misc.	Legal	61
Ginoli & Company	Accountants	7,826
Miscellaneous Vendors	Computer Services	66
Emdeon Business Services	Computer Services	30
Advanced Answers on Demand	Computer Services	3,810
Access 2 Go	Computer Services	366
Ivans	Computer Services	43
Kemper Technology	Computer Services	1,035
VisionShare	Computer Services	322
MediFax	Computer Services	131
LogmeIn	Computer Services	57
Charter Communications	Computer Services	3
Simple LTC	Computer Services	879
Miscellaneous Vendors	Miscellaneous	602
Total (agree to Schedule V, line 19, column 8)		<u>22,945</u>

Facility Name & ID Number Marigold Rehab & Health Care Center# 0049148Report Period Beginning: 1/1/2009Ending: 12/31/2009**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 1,500 IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? 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. \$ 16,010 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. \$ 94,170
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? 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. \$ 14,924
- (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. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out 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.