

		FOR BHF USE					

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0050583

Facility Name: Cumberland Rehab & Health CC

Address: 300 N Marietta St Greenup 62428
Number City Zip Code

County: Cumberland

Telephone Number: (217) 923-3186 Fax # (217) 923-5226

HFS ID Number:

Date of Initial License for Current Owners: 9/22/2006

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Mike Kocher Telephone Number: (309) 673-3009
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2016 to 12/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or
Administrator
of Provider

(Signed)
(Type or Print Name) Mark B. Petersen
(Title) Chief Executive Officer

Paid
Preparer

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

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

Facility Name & ID Number Cumberland Rehab & Health CC

0050583 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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>54</u>	Skilled (SNF)	<u>54</u>	<u>19,710</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>54</u>	TOTALS	<u>54</u>	<u>19,710</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,387</u>	<u>6,423</u>	<u>1,794</u>	<u>13,604</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>5,387</u>	<u>6,423</u>	<u>1,794</u>	<u>13,604</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.02%

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)

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 ☐

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 9/22/2006

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

YES ☒ Date 9/22/2006 NO ☐

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

YES ☒ NO ☐ If YES, enter number of beds certified 54 and days of care provided 1,733

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number **Cumberland Rehab & Health CC** # **0050583** Report Period Beginning: **1/1/2016** Ending: **12/31/2016**
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	104,076	9,200		113,276		113,276	2,794	116,070			1
2	Food Purchase		87,198		87,198		87,198	(2,967)	84,231			2
3	Housekeeping	71,846	11,198		83,044		83,044	49	83,093			3
4	Laundry		6,590		6,590		6,590		6,590			4
5	Heat and Other Utilities			57,308	57,308		57,308	163	57,471			5
6	Maintenance	31,699	8,762	14,198	54,659		54,659	1,526	56,185			6
7	Other (specify):* Home Office Ben. Allocation											7
8	TOTAL General Services	207,621	122,948	71,506	402,075		402,075	1,565	403,640			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	690,197	62,470	12,496	765,163		765,163	(3,230)	761,933			10
10a	Therapy			223,920	223,920		223,920		223,920			10a
11	Activities	21,743	20		21,763		21,763	(6,359)	15,404			11
12	Social Services	18,856	2		18,858		18,858		18,858			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Office Ben. Allocation											15
16	TOTAL Health Care and Programs	730,796	62,492	249,616	1,042,904		1,042,904	(9,589)	1,033,315			16
	C. General Administration											
17	Administrative			190,000	190,000		190,000	(129,600)	60,400			17
18	Directors Fees											18
19	Professional Services			5,108	5,108		5,108	11,326	16,434			19
20	Dues, Fees, Subscriptions & Promotions			5,948	5,948		5,948	298	6,246			20
21	Clerical & General Office Expenses	29,514	1,418	7,726	38,658		38,658	32,552	71,210			21
22	Employee Benefits & Payroll Taxes			119,484	119,484		119,484	18,215	137,699			22
23	Inservice Training & Education							62	62			23
24	Travel and Seminar							30	30			24
25	Other Admin. Staff Transportation			4,135	4,135		4,135	2,563	6,698			25
26	Insurance-Prop.Liab.Malpractice			16,791	16,791		16,791	361	17,152			26
27	Other (specify):* Home Office Ben. Allocation											27
28	TOTAL General Administration	29,514	1,418	349,192	380,124		380,124	(64,193)	315,931			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	967,931	186,858	670,314	1,825,103		1,825,103	(72,217)	1,752,886			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			56,711	56,711		56,711	8,682	65,393			30
31	Amortization of Pre-Op. & Org.							6,534	6,534			31
32	Interest			55,584	55,584		55,584	8,438	64,022			32
33	Real Estate Taxes			19,112	19,112		19,112	166	19,278			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,173	15,173		15,173	586	15,759			35
36	Other (specify):*											36
37	TOTAL Ownership			146,580	146,580		146,580	24,406	170,986			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		45,750		45,750		45,750		45,750			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,247	101,247		101,247		101,247			42
43	Other (specify):*		339	29,151	29,490		29,490	(29,490)				43
44	TOTAL Special Cost Centers		46,089	130,398	176,487		176,487	(29,490)	146,997			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	967,931	232,947	947,292	2,148,170		2,148,170	(77,301)	2,070,869			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,018)	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	1,243	30		9
10	Interest and Other Investment Income	(19)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(153)	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	(18,956)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(855)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,070)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(18,153)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,981)		\$	30

BHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the
general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(36,320)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (36,320)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (77,301)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (4,670)	43	1
2	X-Rays-Part A	(3,601)	43	2
3	Disallowed Special Events	(185)	43	3
4	Offset Miscellaneous Office Supplies Revenue	(25)	21	4
5	Offset Transportation Revenue	(6,359)	11	5
6	Offset Miscellaneous Nursing Revenue	(3,313)	10	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	(18,153)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cumberland Rehab & Health CC# 0050583

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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	2,794	0	0	0	0	0	0	0	0	0	2,794	1
2	Food Purchase	(3,018)	51	0	0	0	0	0	0	0	0	0	(2,967)	2
3	Housekeeping	0	49	0	0	0	0	0	0	0	0	0	49	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	163	0	0	0	0	0	0	0	0	0	163	5
6	Maintenance	0	1,526	0	0	0	0	0	0	0	0	0	1,526	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,018)	4,583	0	0	0	0	0	0	0	0	0	1,565	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	(3,313)	83	0	0	0	0	0	0	0	0	0	(3,230)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(6,359)	0	0	0	0	0	0	0	0	0	0	(6,359)	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	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(9,672)	83	0	0	0	0	0	0	0	0	0	(9,589)	16
	C. General Administration													
17	Administrative	0	(129,600)	0	0	0	0	0	0	0	0	0	(129,600)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,116	0	4,210	0	0	0	0	0	0	0	11,326	19
20	Fees, Subscriptions & Promotions	0	0	298	0	0	0	0	0	0	0	0	298	20
21	Clerical & General Office Expenses	(25)	0	32,577	0	0	0	0	0	0	0	0	32,552	21
22	Employee Benefits & Payroll Taxes	0	0	18,215	0	0	0	0	0	0	0	0	18,215	22
23	Inservice Training & Education	0	0	62	0	0	0	0	0	0	0	0	62	23
24	Travel and Seminar	0	0	30	0	0	0	0	0	0	0	0	30	24
25	Other Admin. Staff Transportation	0	0	2,563	0	0	0	0	0	0	0	0	2,563	25
26	Insurance-Prop.Liab.Malpractice	0	0	361	0	0	0	0	0	0	0	0	361	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(25)	(122,484)	54,106	4,210	0	0	0	0	0	0	0	(64,193)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(12,715)	(117,818)	54,106	4,210	0	0	0	0	0	0	0	(72,217)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cumberland Rehab & Health CC # 0050583 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	1,243	0	7,209	230	0	0	0	0	0	0	0	8,682	30
31	Amortization of Pre-Op. & Org.	0	0	0	6,534	0	0	0	0	0	0	0	6,534	31
32	Interest	(19)	0	212	8,245	0	0	0	0	0	0	0	8,438	32
33	Real Estate Taxes	0	0	166	0	0	0	0	0	0	0	0	166	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	586	0	0	0	0	0	0	0	0	586	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	1,224	0	8,173	15,009	0	0	0	0	0	0	0	24,406	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):*	(29,490)	0	0	0	0	0	0	0	0	0	0	(29,490)	43
44	TOTAL Special Cost Centers	(29,490)	0	0	0	0	0	0	0	0	0	0	(29,490)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(40,981)	(117,818)	62,279	19,219	0	0	0	0	0	0	0	(77,301)	45

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

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

1		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 Management, Inc.	100.00%	\$ 2,794	\$ 2,794	1
2	V	2	Food		Petersen Health Care Management, Inc.	100.00%	51	51	2
3	V	3	Housekeeping		Petersen Health Care Management, Inc.	100.00%	49	49	3
4	V	5	Utilities		Petersen Health Care Management, Inc.	100.00%	163	163	4
5	V	6	Maintenance		Petersen Health Care Management, Inc.	100.00%	1,526	1,526	5
6	V	7	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		6
7	V	9	Medical Director		Petersen Health Care Management, Inc.	100.00%	0		7
8	V	10	Nursing and Medical Records		Petersen Health Care Management, Inc.	100.00%	83	83	8
9	V	10A	Therapy		Petersen Health Care Management, Inc.	100.00%	0		9
10	V	15	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		10
11	V	17	Administrative	190,000	Petersen Health Care Management, Inc.	100.00%	60,400	(129,600)	11
12	V	19	Professional Services		Petersen Health Care Management, Inc.	100.00%	7,116	7,116	12
13	V								13
14	Total			\$ 190,000			\$ 72,182	\$ * (117,818)	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 & Promotions	\$	Petersen Health Care Management, Inc.	100.00%	\$ 298	\$ 298	15
16	V	21	Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	32,577	32,577	16
17	V	22	Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	18,215	18,215	17
18	V	23	Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	62	62	18
19	V	24	Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	30	30	19
20	V	25	Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,563	2,563	20
21	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	361	361	21
22	V	27	Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	0		22
23	V	30	Depreciation		Petersen Health Care Management, Inc.	100.00%	7,209	7,209	23
24	V	32	Interest		Petersen Health Care Management, Inc.	100.00%	212	212	24
25	V	33	Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	166	166	25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	586	586	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			\$			\$ 62,279	\$ * 62,279	39

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

Facility Name & ID Number Cumberland Rehab & Health CC# 0050583Report Period Beginning: 1/1/2016Ending: 12/31/2016

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 Network, LLC	100.00%	\$ 0	\$ 15
16	V	2 Food		Petersen Health Network, LLC	100.00%	0	16
17	V	3 Housekeeping		Petersen Health Network, LLC	100.00%	0	17
18	V	4 Laundry		Petersen Health Network, LLC	100.00%	0	18
19	V	5 Utilities		Petersen Health Network, LLC	100.00%	0	19
20	V	6 Maintenance		Petersen Health Network, LLC	100.00%	0	20
21	V	7 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0	21
22	V	10 Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0	22
23	V	15 Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0	23
24	V	17 Administrative		Petersen Health Network, LLC	100.00%	0	24
25	V	19 Professional Services		Petersen Health Network, LLC	100.00%	4,210	4,210 25
26	V	20 Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	0	26
27	V	21 Clerical and General Office		Petersen Health Network, LLC	100.00%	0	27
28	V	22 Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	0	28
29	V	23 Inservice Training & Education		Petersen Health Network, LLC	100.00%	0	29
30	V	24 Travel and Seminar		Petersen Health Network, LLC	100.00%	0	30
31	V	25 Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	0	31
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0	32
33	V	30 Depreciation		Petersen Health Network, LLC	100.00%	230	230 33
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	6,534	6,534 34
35	V	32 Interest		Petersen Health Network, LLC	100.00%	8,245	8,245 35
36	V	33 Real Estate Taxes		Petersen Health Network, LLC	100.00%	0	36
37	V	34 Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0	37
38	V	35 Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	0	38
39	Total		\$			\$ 19,219	\$ * 19,219 39

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

Facility Name & ID Number

Cumberland Rehab & Health CC

0050583

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Hospitality L	Peoria	Hospitality	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Management	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Busin	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Lessor	13
14			Decatur Rehab & Health Care Center	Decatur	Midwest Health Opera	Peoria	Mgmt/Bookkeeping	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Health Prope	Peoria	Mgmt/Bookkeeping	15
16			Eastview Terrace	Sullivan	Petersen Roseville, LL	Roseville	Lessor	16
17			El Paso Health Care Center	El Paso	Petersen Health Juncti	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Petersen Health Qualit	Peoria	Mgmt/Bookkeeping	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Health and W	Peoria	Mgmt/Bookkeeping	19
20			Flanagan Rehab & Health Care Center	Flanagan	Petersen 24, LLC	Peoria	Hospitality	20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Cumberland Rehab & Health CC

0050583

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

Facility Name & ID Number

Cumberland Rehab & Health CC

0050583

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

VII. RELATED PARTIES

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

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number Cumberland Rehab & Health CC # 0050583 Report Period Beginning: 1/1/2016 Ending: 12/31/2016

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									\$		1
2											2
3	N/A										3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number Cumberland Rehab & Health CC# 0050583

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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	1,521,544	75	\$ 312,540	\$ 357,910	13,604	\$ 2,794	1
2	2	Food	Resident Days	1,521,544	75	5,673	0	13,604	51	2
3	3	Housekeeping	Resident Days	1,521,544	75	5,456	2,897	13,604	49	3
4	5	Utilities	Resident Days	1,521,544	75	18,209	0	13,604	163	4
5	6	Maintenance	Resident Days	1,521,544	75	170,632	137,057	13,604	1,526	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	13,604	0	6
7	9	Medical Director	Resident Days	1,521,544	75	0	0	13,604	0	7
8	10	Nursing and Medical Records	Resident Days	1,521,544	75	9,261	1,782,521	13,604	83	8
9	10A	Therapy	Resident Days	1,521,544	75	0	0	13,604	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	13,604	0	10
11	17	Administrative	Resident Days	1,521,544	75	4,899,467	5,473,961	13,604	60,400	11
12	19	Professional Services	Resident Days	1,521,544	75	795,918	0	13,604	7,116	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,521,544	75	33,278	0	13,604	298	13
14	21	Clerical and General Office	Resident Days	1,521,544	75	3,643,535	3,756,135	13,604	32,577	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,521,544	75	2,037,314	0	13,604	18,215	15
16	23	Inservice Training & Education	Resident Days	1,521,544	75	6,986	0	13,604	62	16
17	24	Travel and Seminar	Resident Days	1,521,544	75	3,389	0	13,604	30	17
18	25	Other Admin. Staff Transport.	Resident Days	1,521,544	75	286,637	0	13,604	2,563	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,521,544	75	40,378	0	13,604	361	19
20	27	Mgmt. Allocation of Benefits	Resident Days	1,521,544	75	0	0	13,604	0	20
21	30	Depreciation	Resident Days	1,521,544	75	806,271	0	13,604	7,209	21
22	32	Interest	Resident Days	1,521,544	75	23,686	0	13,604	212	22
23	33	Real Estate Taxes	Resident Days	1,521,544	75	18,560	0	13,604	166	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,521,544	75	65,550	0	13,604	586	24
25	TOTALS					\$ 13,182,740	\$ 11,510,481		\$ 134,461	25

Facility Name & ID Number Cumberland Rehab & Health CC# 0050583

Report Period Beginning:

1/1/2016Ending: 2/31/2016

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 Network, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309)691-8113

Fax Number

(309)691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	251,294	13	\$	\$	13,604	\$	1
2	2	Food	Resident Days	251,294	13			13,604		2
3	3	Housekeeping	Resident Days	251,294	13			13,604		3
4	4	Laundry	Resident Days	251,294	13			13,604		4
5	5	Utilities	Resident Days	251,294	13			13,604		5
6	6	Maintenance	Resident Days	251,294	13			13,604		6
7	7	Mgmt. Allocation of Benefits	Resident Days	251,294	13			13,604		7
8	10	Nursing and Medical Records	Resident Days	251,294	13			13,604		8
9	15	Mgmt. Allocation of Benefits	Resident Days	251,294	13			13,604		9
10	17	Administrative	Resident Days	251,294	13			13,604		10
11	19	Professional Services	Resident Days	251,294	13	77,776		13,604	4,210	11
12	20	Dues, Fees, Subs & Promotions	Resident Days	251,294	13			13,604		12
13	21	Clerical and General Office	Resident Days	251,294	13			13,604		13
14	22	Employee Benefits & Payroll	Resident Days	251,294	13			13,604		14
15	23	Inservice Training & Education	Resident Days	251,294	13			13,604		15
16	24	Travel and Seminar	Resident Days	251,294	13			13,604		16
17	25	Other Admin. Staff Transport.	Resident Days	251,294	13			13,604		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	251,294	13			13,604		18
19	30	Depreciation	Resident Days	251,294	13	4,252		13,604	230	19
20	31	Amortization	Resident Days	251,294	13	120,699		13,604	6,534	20
21	32	Interest	Resident Days	251,294	13	152,300		13,604	8,245	21
22	33	Real Estate Taxes	Resident Days	251,294	13			13,604		22
23	34	Rent-Facility and Grounds	Resident Days	251,294	13			13,604		23
24	35	Rent-Equipment & Vehicles	Resident Days	251,294	13			13,604		24
25	TOTALS					\$ 355,027	\$		\$ 19,219	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Wells Fargo		X	Mortgage	Varies	1/1/2015	\$ 1,171,744	\$ 1,075,105	12/31/2034	Varies	\$ 55,584	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,171,744	\$ 1,075,105			\$ 55,584	9	
	B. Non-Facility Related*												
10								Interest Income Offset			(19)	10	
11								Home Office Allocation-PHN			8,245	11	
12								Home Office Allocation-PHCM			212	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 8,438	14	
15	TOTALS (line 9+line14)						\$ 1,171,744	\$ 1,075,105			\$ 64,022	15	

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

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

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

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

B. Real Estate Taxes

[illegible]

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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cumberland Rehab & Health CC COUNTY Cumberland

FACILITY IDPH LICENSE NUMBER 0050583

CONTACT PERSON REGARDING THIS REPORT MIKE KOCHER

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 13-02-203-015	Long-Term Care Facility	\$ 89.74	\$ 89.74
2. 13-02-203-016	Long-Term Care Facility	\$ 31.66	\$ 31.66
3. 13-02-203-017	Long-Term Care Facility	\$ 17,569.32	\$ 17,569.32
4. 13-02-203-020	Long-Term Care Facility	\$ 173.64	\$ 173.64
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 17,864.36	\$ 17,864.36

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

A. Square Feet: 20,870

B. General Construction Type: Exterior BrickFrame Cement BlockNumber 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: 561,304

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

3. Current Period Amortization: 6,534

4. Dates Incurred: 2013-2014

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.					
	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	328,878	2006	\$ 140,000	1
2					2
3	TOTALS	328,878		\$ 140,000	3

Facility Name & ID Number Cumberland Rehab & Health CC

0050583

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	60		2006	1969	\$ 1,150,000	\$	30	\$ 38,667	\$ 38,667	\$ 406,002
5										
6										
7										
8										
	Improvement Type**									
9	Blinds/Window Treatments			2007	13,495		10			13,495
10	Parking Lot			2007	4,500		15	300	300	2,850
11	Dry valve replacement			2008	3,653		15	244	244	2,074
12	Wall Repair			2012	11,730		15	782	782	3,519
13	Furnaces			2013	5,345		15	356	356	1,246
14	Vinyl Plank Flooring in Common Area			2014	4,930		15	329	329	823
15	Parking Lot Paving			2015	32,500		15	2,168	2,168	3,252
16	Remodeling of 4 Medicare Rooms-Painting, Flooring, Bedding			2016	13,100		10	655	655	655
17	Concrete Sidewalk Replacement			2016	22,092		15	736	736	736
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30	Land Improvements Booked					1,582			(1,582)	
31	Building Booked					45,600			(45,600)	
32	Building Improvement Booked					6,866			(6,866)	
33										
34	2016-Home Office Allocation-Building Improvements				6,006			144	144	
35	2016-Home Office Allocation-Land Improvements				553			36	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 Cumberland Rehab & Health CC

0050583

Report Period Beginning:

1/1/2016

Ending:

12/31/2016

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,267,904	\$ 54,048		\$ 44,417	\$ (9,631)	\$ 434,652	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$228,859	\$1,300	\$12,666	\$11,366	5-10 yrs.	\$221,042	71
72	Current Year Purchases	14,714	1,363	1,051	(312)	7 yrs.	1,051	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			7,259	7,259			74
75	TOTALS	\$243,573	\$2,663	\$20,976	\$18,313		\$222,093	75

D. Vehicle Costs. (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	Facility	2007 Ford Econoline Van	2007	\$28,328	\$	\$	\$		\$28,328
77									
78									
79									
80	TOTALS			\$28,328	\$	\$	\$		\$28,328

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$1,679,805	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$56,711	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$65,393	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$8,682	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$685,073	

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		\$	\$	\$
87				
88	N/A			
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94	N/A	
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: \$ 15,759 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

* 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.

Cumberland Rehab & Health CC
0050583

Period Beginning 1/1/2016
Period End 12/31/2016

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	8,788
Dishwasher		1,020
Copier		5,365
Home Office Allocation		586
		<u>15,759</u>

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	\$	5,491	\$ 82,367	\$	5,491	\$ 82,367	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,350	35,255		2,350	35,255	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,847	106,298		6,847	106,298	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				45,750		45,750	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	14,688	\$ 223,920	\$ 45,750	14,688	\$ 269,670	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.

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	\$ 1,500,252	\$ 1,500,252	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 110,980)	551,927	551,927	3
4	Supply Inventory (priced at Cost)	7,083	7,083	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,792	15,792	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,075,054	\$ 2,075,054	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	163,732	140,000	13
14	Buildings, at Historical Cost	1,140,000	1,156,006	14
15	Leasehold Improvements, at Historical Cost	110,055	111,898	15
16	Equipment, at Historical Cost	271,901	271,901	16
17	Accumulated Depreciation (book methods)	(764,658)	(685,073)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 921,030	\$ 994,732	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,996,084	\$ 3,069,786	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 392,916	\$ 392,916	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	51,454	51,454	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,249	17,249	31
32	Accrued Real Estate Taxes(Sch.IX-B)	18,396	18,396	32
33	Accrued Interest Payable	4,739	4,739	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Withholdings	18,527	18,527	36
37	Accrued Management Fees	18,257	18,257	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 521,538	\$ 521,538	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,075,105	1,075,105	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)	\$ 1,075,105	\$ 1,075,105	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,596,643	\$ 1,596,643	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,399,441	\$ 1,473,143	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,996,084	\$ 3,069,786	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,138,954	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)	\$ 1,138,955	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	260,486	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)	\$ 260,486	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)	\$ 1,399,441	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Cumberland Rehab & Health CC

0050583

Report Period Beginning: 1/1/2016

Ending: 12/31/2016

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,060,961	1
2	Discounts and Allowances for all Levels	(194,506)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,866,455	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	418,744	6
7	Oxygen	335	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 419,079	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		13
14	Non-Patient Meals	3,018	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	87,392	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	6,020	20
21	Other Medical Services	16,976	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 113,406	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Transportation Revenue</u>	6,359	28
28a	<u>Miscellaneous Revenue</u>	3,338	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 9,697	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,408,656	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	402,075	31
32	Health Care	1,042,904	32
33	General Administration	380,124	33
	B. Capital Expense		
34	Ownership	146,580	34
	C. Ancillary Expense		
35	Special Cost Centers	75,240	35
36	Provider Participation Fee	101,247	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,148,170	40
41	Income before Income Taxes (line 30 minus line 40)**	260,486	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 260,486	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 660,835	44
45	Private Pay - Net Inpatient Revenue	853,346	45
46	Medicare - Net Inpatient Revenue	346,842	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	5,432	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,866,455	49

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

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

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

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

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	\$ 60,900	\$ 29.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,099	5,462	128,737	23.57	3
4	Licensed Practical Nurses	9,739	10,183	200,454	19.69	4
5	CNAs & Orderlies	23,377	23,895	255,681	10.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,688	1,744	21,743	12.47	9
10	Activity Assistants					10
11	Social Service Workers	1,483	1,483	18,856	12.71	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	30,445	14.64	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,354	8,577	73,631	8.58	15
16	Dishwashers					16
17	Maintenance Workers	1,982	2,107	31,699	15.04	17
18	Housekeepers	7,140	7,418	71,846	9.69	18
19	Laundry					19
20	Administrator	2,080	2,080	60,400	29.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,873	2,065	29,514	14.29	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) CPC	1,908	1,908	44,425	23.28	33
34	TOTAL (lines 1 - 33)	68,883	71,082	\$ 1,028,331 *	\$ 14.47	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	13,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,986	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant	2	116	L10A, C3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2	\$ 16,302		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				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

STATE OF ILLINOIS

Facility Name & ID Number

Cumberland Rehab & Health CC

0050583

Report Period Beginning:

1/1/2016

Page 21

Ending:

12/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
Katherine Hanner		Administrator	0	\$ 60,400	Workers' Compensation Insurance		\$ 21,719	IDPH License Fee		\$	
					Unemployment Compensation Insurance		19,422	Advertising: Employee Recruitment			
					FICA Taxes		72,481	Health Care Worker Background Check			
					Employee Health Insurance		4,456	(Indicate # of checks performed 30)		416	
					Employee Meals			Patient Background Checks 20		277	
					Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses & Permits		465	
					Employee Relations		1,236	Miscellaneous Dues & Subscriptions		4,790	
					Employee Retirement		170	Home Office Allocation		298	
					Home Office Allocation		18,215				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$ 60,400	TOTAL (agree to Schedule V, line 22, col.8)			\$ 137,699	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,246
B. Administrative - Other					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Description				Amount	Description		Line #	Amount	Description		Amount
Management Fees-See Page 6, Eliminated on P 3, C 7				\$ 190,000	N/A				Out-of-State Travel		\$
									In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$ 190,000	TOTAL			\$	Seminar Expense		
C. Professional Services									Home Office Allocation		30
Vendor/Payee		Type		Amount					Entertainment Expense		()
E-Health Data Solutions		Computer Services		\$ 2,221					(agree to Sch. V, line 24, col. 8)		
Mediacom		Computer Services		1,631					TOTAL		\$ 30
Allscripts		Computer Services		961							
Ability Network		Computer Services		102							
Everhart & Everhart Abstractors		Legal Fees		125							
HK Payroll Services		Professional Fees		68							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$ 5,108							

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Cumberland Rehab & Health CC
0050583

Period Beginning

1/1/2016

Period End

12/31/2016

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		5,108
Home Office Allocation		
Lucie, Scalf, and Bougher	Legal	32
Miscellaneous	Legal	10
Miller Hall and Triggs	Legal	55
Healthcare Resources International	Legal	658
Hunziker Law	Legal	66
Lexis Nexis	Legal	6
Wells Fargo	Legal	302
CliftonLarson Allen	Accountants	285
Ginoli & Co.	Accountants	3,670
Wells Fargo	Accountants	787
Miscellaneous	Computer Services	36
Change Healthcare	Computer Services	5
PTC Select	Computer Services	3
Advanced Answers on Demand	Computer Services	2,505
Stratus Networks	Computer Services	255
Kemper Technology	Computer Services	168
AT&T	Computer Services	4
Ability Network	Computer Services	1,068
CIA/N	Computer Services	127
Comcast	Computer Services	21
CCH	Computer Services	8
Charter Communications	Computer Services	25
Allscripts	Computer Services	372
ATS	Computer Services	168
Allpayer Exchange	Computer Services	8
Optimizer	Other Prof Fees	26
Ankura	Other Prof Fees	194
David Budde	Other Prof Fees	22
Bruner, Cooper, Zuck	Other Prof Fees	57
Marotta, Gund, Budd, Dzerda	Other Prof Fees	350
Professional Software and Services	Other Prof Fees	14
Hughes Valuation Services	Other Prof Fees	18
Alan Litwiller	Other Prof Fees	1

Total (agree to Schedule V, line 19, column 8)	<u>16,434</u>
--	---------------

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?
If YES, give association name and amount.

Yes
ICHA \$4,790.04

(3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

No
N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
N/A

(5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

Yes
7 yrs.

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 16,322 Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
N/A

(9)

Are you presently operating under a sublease agreement?

YES X NO

(10)

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

(11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 101,247

(12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(15)

Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V.
Has any meal income been offset against related costs?

\$ 0
Yes
Indicate the amount. \$ 3,018

(16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

Yes
\$ 6,359

c.

What percent of all travel expense relates to transportation of nurses and patients?

100

d.

Have vehicle usage logs been maintained?

Adequate records have been maintained.

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

Yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

Yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

Yes
Ginoli and Company

(18)

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

Yes

(19)

Has a schedule for the legal fees reported on the cost report been provided by the facility?
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees

No

HFS 3745 (N-4-99)

IL478-2471

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Det	-77,301	equal to	-77,301	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expensi	64,022	equal to	64,022	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax	19,278	equal to	19,278	0	FAILED	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exj	6,534	equal to	6,534	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Cost	65,393	equal to	65,393	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	15,759	equal to	15,759	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Traini	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Service	223,920	equal to	223,920	0	O.K.	Pg16 Z12+Z14..	N/A,B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- S	45,750	equal to	45,750	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. Ge	402,075	equal to	402,075	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. He	1,042,904	equal to	1,042,904	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Ad	380,124	equal to	380,124	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ov	146,580	equal to	146,580	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Sp	75,240	equal to	75,240	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Pri	101,247	equal to	101,247	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	690,197	equal to	690,197	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aidi	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed T	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	21,743	equal to	21,743	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Sei	18,856	equal to	18,856	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	104,076	equal to	104,076	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenar	31,699	equal to	31,699	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekee	71,846	equal to	71,846	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to		#VALUE!	#VALUE!	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administr	60,400	equal to	60,400	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	29,514	equal to	29,514	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical D	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries A	1,028,331	equal to	967,931	60,400	FAILED	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consult	0	< or = to		#VALUE!	#VALUE!	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	13,200	< or = to	13,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & c	3,102	< or = to	12,496	-9,394	O.K.	Pg20 X14..X16+	B. & C.	17to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consult	0	< or = to		#VALUE!	#VALUE!	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service C	0	< or = to		0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- A	60,400	equal to	60,400	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- A	190,000	equal to	190,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- F	5,108	equal to	5,108	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- E	137,699	equal to	137,699	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- S	6,246	equal to	6,246	0	FAILED	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- S	30	equal to	30	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Parti	101,247	equal to	101,247	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Emp	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide train	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medical	1,733	equal to	1,794	-61	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for r	-36,320	equal to	-36,320	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4I	B.	14	8
Total loan balan	1,075,105	equal to	1,075,105	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax i	18,396	equal to	18,396	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	140,000	equal to	140,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,267,904	equal to	1,267,904	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and i	271,901	equal to	271,901	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated de	685,073	equal to	685,073	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equ	1,399,441	equal to	1,399,441	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (los	260,486	equal to	260,486	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized de	0	equal to		0	O.K.	Pg22 F31-J31..J	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,996,084	equal to	2,996,084	0	O.K.	Pg17:H41	N/A	25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Total
1. Dietary	104,076	9,200	0	113,276	0	113,276	2,794	116,070
2. Food Purchase	0	87,198	0	87,198	0	87,198	-2,967	84,231
3. Housekeeping	71,846	11,198	0	83,044	0	83,044	49	83,093
4. Laundry	0	6,590	0	6,590	0	6,590	0	6,590
5. Heat and Other Utilities	0	0	57,308	57,308	0	57,308	163	57,471
6. Maintenance	31,699	8,762	14,198	54,659	0	54,659	1,526	56,185
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	207,621	122,948	71,506	402,075	0	402,075	1,565	403,640
9. Medical Director	0	0	13,200	13,200	0	13,200	0	13,200
10. Nursing & Medical Records	690,197	62,470	12,496	765,163	0	765,163	-3,230	761,933
10a. Therapy	0	0	223,920	223,920	0	223,920	0	223,920
11. Activities	21,743	20	0	21,763	0	21,763	-6,359	15,404
12. Social Services	18,856	2	0	18,858	0	18,858	0	18,858
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	730,796	62,492	249,616	1,042,904	0	1,042,904	-9,589	#####
17. Administrative	0	0	190,000	190,000	0	190,000	-129,600	60,400
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	5,108	5,108	0	5,108	11,326	16,434
20. Fees, Subscriptions & Promotion	0	0	5,948	5,948	0	5,948	298	6,246
21. Clerical & General Office	29,514	1,418	7,726	38,658	0	38,658	32,552	71,210
22. Employee Benefits & Payroll	0	0	119,484	119,484	0	119,484	18,215	137,699
23. Inservice Training & Education	0	0	0	0	0	0	62	62
24. Travel and Seminar	0	0	0	0	0	0	30	30
25. Other Admin. Staff Trans	0	0	4,135	4,135	0	4,135	2,563	6,698
26. Insurance-Prop.Liab.Malpractice	0	0	16,791	16,791	0	16,791	361	17,152
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	29,514	1,418	349,192	380,124	0	380,124	-64,193	315,931
29. Total General Administrative	967,931	186,858	670,314	1,825,103	0	1,825,103	-72,217	#####
30. Depreciation	0	0	56,711	56,711	0	56,711	8,682	65,393
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	6,534	6,534
32. Interest	0	0	55,584	55,584	0	55,584	8,438	64,022
33. Real Estate	0	0	19,112	19,112	0	19,112	166	19,278
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	15,173	15,173	0	15,173	586	15,759
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	146,580	146,580	0	146,580	24,406	170,986
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	45,750	0	45,750	0	45,750	0	45,750
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	101,247	101,247	0	101,247	0	101,247
43. Other (specify):*	0	339	29,151	29,490	0	29,490	-29,490	0
44. Total Special Cost Ce	0	46,089	130,398	176,487	0	176,487	-29,490	146,997
45. Grand Total	967,931	232,947	947,292	2,148,170	0	2,148,170	-77,301	#####

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,500,252	1,500,252
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	551,927	551,927
4. Supply Inventory	7,083	7,083
5. Short-Term Investments	0	0
6. Prepaid Insurance	15,792	15,792
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	2,075,054	2,075,054
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	163,732	140,000
14. Buildings, at Historical Cost	1,140,000	1,156,006
15. Leasehold Improvements, Historical Cost	110,055	111,898
16. Equipment, at Historical Cost	271,901	271,901
17. Accumulated Depreciation (book methods)	-764,658	-685,073
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	921,030	994,732
25. Total Assets	2,996,084	3,069,786
CURRENT LIABILITIES		
26. Accounts Payable	392,916	392,916
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	51,454	51,454
31. Accrued Taxes Payable	17,249	17,249
32. Accrued Real Estate Taxes	18,396	18,396
33. Accrued Interest Payable	4,739	4,739
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	18,527	18,527
37. Other Current Liabilities (specify):	18,257	18,257
38. Total Current Liabilities	521,538	521,538
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	1,075,105	1,075,105
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,075,105	1,075,105
46.Total Liabilities	1,596,643	1,596,643
47.Total Equity	1,399,441	1,473,143
48.Total Liabilities and Equity	2,996,084	3,069,786

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,060,961
2. Discounts and Allowances for all Levels	-194,506
Subtotal - Inpatient Care	1,866,455
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	418,744
7. Oxygen	335
Subtotal - Ancillary Revenue	419,079
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	3,018
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	87,392
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	6,020
21. Other Medical Services	16,976
22. Laundry	0
Subtotal - Other Operating Revenue	113,406
24. Contributions	0
25. Interest and Other Investments Income	19
Subtotal - Non-Operating Revenue	19
27. Other Revenue (specify):	6,359
28. Other Revenue (specify):	3,338
Subtotal - Other Revenue	9,697
30. Total Revenue	2,408,656
31. General Services	382,536
32. Health Care	1,047,685
33. General Administration	374,530
34. Ownership	133,568
35. Special Cost Centers	95,819
35. Provider Participation Fee	89,999
37. Other	0
40. Total Expenses	2,124,137
41. Income Before Income Taxes	284,519
42. Income Taxes	0
43. Net Income or Loss for the Year	284,519