		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0055814

Facility Name: Cumberland Rehab Health CC

Address: 300 N Marietta St (Number) Greenup (City) 62428 (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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Kevin Wellen, CPA **Telephone Number:** (314) 925-4300
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 1/1/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	(Date)
	(Print Name and Title)	Kevin Wellen, CPA Signing Director
	(Firm Name & Address)	CliftonLarsonAllen LLP 600 Washington Ave, Ste. 1800, St. Louis, MO 63101
	(Telephone)	(314) 925-4300 Fax # (314) 925-4350

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 **Phone # (217) 782-1630**

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	54	Skilled (SNF)	54	19,710	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	54	TOTALS	54	19,710	7

B. Census-For the entire report period.

	1 Level of Care	2 Medicaid Fee for Service	3 Medicaid MLTSS	4 MMAI Medicaid Primary	5 MMAI Medicare Primary	6 Private Pay	7 Medicare Part A Only	8 Other	9 Total	
		Patient Days by Level of Care and Primary Source of Payment								
8	SNF	2,042	2,461	1,016		3,172	893	1,968	11,552	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,042	2,461	1,016		3,172	893	1,968	11,552	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 58.61%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/22/2006

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/22/2006 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter certified beds.
number of certified beds 54

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,299	13,232	11,726	197,257		197,257		197,257			1
2	Food Purchase		121,772		121,772		121,772	(1)	121,771			2
3	Housekeeping	102,254	9,438		111,692		111,692		111,692			3
4	Laundry	39,779	3,005		42,784		42,784		42,784			4
5	Heat and Other Utilities			61,012	61,012		61,012		61,012			5
6	Maintenance	42,608	11,405	64,771	118,784		118,784		118,784			6
7	Other (specify):*											7
8	**TOTAL General Services**	356,940	158,852	137,509	653,301		653,301	(1)	653,300			8
	B. Health Care and Programs											
9	Medical Director			17,400	17,400		17,400		17,400			9
10	Nursing and Medical Records	1,043,355	48,365	37,311	1,129,031		1,129,031		1,129,031			10
10a	Therapy											10a
11	Activities	31,811	486	149	32,446		32,446		32,446			11
12	Social Services	30,745		6,596	37,341		37,341		37,341			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,105,911	48,851	61,456	1,216,218		1,216,218		1,216,218			16
	C. General Administration											
17	Administrative	82,572		190,439	273,011		273,011		273,011			17
18	Directors Fees											18
19	Professional Services			250,205	250,205		250,205	619	250,824			19
20	Dues, Fees, Subscriptions & Promotions			8,947	8,947		8,947		8,947			20
21	Clerical & General Office Expenses	50,980	9,246	630,404	690,630		690,630	(490,072)	200,558			21
22	Employee Benefits & Payroll Taxes			169,990	169,990		169,990		169,990			22
23	Inservice Training & Education			2,672	2,672		2,672		2,672			23
24	Travel and Seminar			6,354	6,354		6,354		6,354			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			102,364	102,364		102,364		102,364			26
27	Other (specify):*											27
28	**TOTAL General Administration**	133,552	9,246	1,361,375	1,504,173		1,504,173	(489,453)	1,014,720			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,596,403	216,949	1,560,340	3,373,692		3,373,692	(489,454)	2,884,238			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 Cumberland Rehab Health CC #0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			1,396	1,396		1,396		1,396			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,688	11,688		11,688	(342)	11,346			32
33	Real Estate Taxes			22,967	22,967		22,967		22,967			33
34	Rent-Facility & Grounds			100,161	100,161		100,161		100,161			34
35	Rent-Equipment & Vehicles			3,847	3,847		3,847		3,847			35
36	Other (specify):*											36
37	**TOTAL Ownership**			140,059	140,059		140,059	(342)	139,717			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		68,794	320,293	389,087		389,087		389,087			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			198,567	198,567		198,567		198,567			42
43	Other (specify):* **Marketing**			27,767	27,767		27,767	(27,767)				43
44	**TOTAL Special Cost Centers**		68,794	546,627	615,421		615,421	(27,767)	587,654			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,596,403	285,743	2,247,026	4,129,172		4,129,172	(517,563)	3,611,609			45

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

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	(1)	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				9
10	Interest and Other Investment Income	(342)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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	(11,455)	21		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	(474,983)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(30,782)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (517,563)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (517,563)		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

Cumberland Rehab Health CC

ID# 0055814

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Political Action Committee Payments	$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	AL/IL/Marketing other	(27,767)	43	3
4	Late Fees	545	21	4
5	Data Processing Fees	619	19	5
6	Misc. Income	(4,257)	21	6
7	COVID Expense	78	21	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**	(30,782)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1)	0	0	0	0	0	0	0	0	0	0	(1)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1)	0	0	0	0	0	0	0	0	0	0	(1)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	619	0	0	0	0	0	0	0	0	0	0	619	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(490,072)	0	0	0	0	0	0	0	0	0	0	(490,072)	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(489,453)	0	0	0	0	0	0	0	0	0	0	(489,453)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(489,454)	0	0	0	0	0	0	0	0	0	0	(489,454)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 **Report Period Beginning:** 1/1/2025 **Ending:** 12/31/2025

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

	Capital Expense D. Ownership	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)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(342)	0	0	0	0	0	0	0	0	0	0	(342)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(342)	0	0	0	0	0	0	0	0	0	0	(342)	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):*	(27,767)	0	0	0	0	0	0	0	0	0	0	(27,767)	43
44	**TOTAL Special Cost Centers**	(27,767)	0	0	0	0	0	0	0	0	0	0	(27,767)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(517,563)	0	0	0	0	0	0	0	0	0	0	(517,563)	45

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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
		See page 6 Supplemental		See page 6 Supplemental		

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 [X] NO

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

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

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

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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 [X] NO

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

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

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

STATE OF ILLINOIS **Ownership Listing-1**

Cumberland Rehab Health CC

ID# **0055814**

Report Period Beginning: **1/1/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
1	Mark	B	Petersen	Peoria	IL	100.00000			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
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51									51
52									52
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67									67
68									68
69									69
70									70
71									71
72									72
73									73
74									74
75									75

STATE OF ILLINOIS **Ownership Listing-2**

Cumberland Rehab Health CC

ID# **0055814**

Report Period Beginning: **1/1/2025**

Ending: **12/31/2025**

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)
-Owners of companies must be listed instead of company names.
-Names of trust beneficiaries must be listed.

	First Name	M.I.	Last Name	Place of Residence City	State	Operator/Licensee Ownership Percentage	Building Co. Ownership Percentage	Management Co. /Home Office Ownership Percentage	
76									76
77									77
78									78
79									79
80									80
81									81
82									82
83									83
84									84
85									85
86									86
87									87
88									88
89									89
90									90
91									91
92									92
93									93
94									94
95									95
96									96
97									97
98									98
99									99
100									100
101									101
102									102
103									103
104									104
105									105
106									106
107									107
108									108
109									109
110									110
111									111
112									112
113									113
114									114
115									115
116									116
117									117
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123									123
124									124
125									125
126									126
127									127
128									128
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131									131
132									132
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134									134
135									135
136									136
137									137
138									138
139									139
140									140
141									141
142									142
143									143
144									144
145									145
146									146
147									147
148									148
149									149
150									150

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Aleso Health Care Center	Aledo	Mason Point	Sullivan	Peterson Companies	Peoria		1
2	Arcola Health Care Center	Arcola	McLeansborr Rehab & Health Care Center	McLeansboro	Petersen Health Care	Peoria		2
3	Aspen Rehab & Health Center	Silvis	Mt Vernon Health Care Center	Mt. Vernon	Peterson Health Care'	Peoria		3
4	Batavia Rehab & Health Care Center	Batavia	Newman Rehab & Health Care Center	Newman	Peterson Health Opert	Peoria		4
5	Bement Health Care Center	Bement	Nokomis Rehab & Health Care center	Nokomis	Perterson Health Syste	Peoria		5
6	Benton Rehab & Health Care Center	Benton	North Aurora Care Center	North Aurora	Petersen Hotels, LLC	Peoria		6
7	Bloomington Rehab & Health Care Center	Bloomington	Palm Terrace of Mattoon	Mattoon	Petersen Hospitality L	Peoria		7
8	Casey Health Care Center	Casey	Piper city Rehab & Living Center	Piper City	Petersen Health Care	Peoria		8
9	Charleston Rehab & Health Care Center	Charleston	Pleasant View Rehab & Health Care Center	Morrison	Petersen Management	Peoria		9
10	Cisne Rehab & Health Care Center	Cisne	Polo Rehabilitation & Health Care Center	Polo	Petersen Health Busin	Peoria		10
11	Countryview Care Center of Macomb	Macomb	Prairie City Rehab & Health Care Center	Prairie City	Petersen Health Care	Sulliva		11
12	Counterview Terrance	Louisville	Robings Manor Nursing Home	Brighton	Midwest Health Opera	Peoria		12
13	Cumberland Rehab & Health Care Center	Greenup	Rochelle Gardens	Rochelle	Petersen Health Prope	Peoria		13
14	Decatur Rehab & Health Care Center	Decatur	Rochelle Rehab & Health Care Center	Rochelle	Petersen Roseville LL	Roseville		14
15	Eastside Health & Rehabiliation Center'	Pittsfield	Rock Falls Rehab & Health Care Center	Rock Falls	Petersen Health Quali	Peoria		15
16	Eastview Terrace	Sullivan	Arrow Wood Independent Living	Rock Falls	Petersen Health and	Peoria		16
17	El Paso Health Care Center	El Paso	Roseville Rehab & Health Care Center	Roseville	Petersen 24, LLC	Peoria		17
18	Enfield Rehab & Health Care Center	Enfield	Rosiclare Rehab & Health Care Center	Rosiclare				18
19	Farmer City Rehab & Health Care Center	Farmer City	Royal Oaks Care Center	Kewanee				19
20	Flanagan Rehab & Health Care Center	Flanagan	Sandwich Rehab & Health Care Center	Sandwich				20
21	Flora Gardens Care Center	Flora	Iron Wood Independent Living	Sandwich				21
22	Flora Health Care Center	Flora	Shawnee Rose Care Center	Harrisburg				22
23	Fondulac Rehab & Health Care Center	East Peoria	Shelbyville Rehab & Health Care Center	Shelbyville				23
24	Havana Health Care Center	Havana	South Elgin Rehab & Health Care Center	South Elgin				24
25	Illini Heritage Rehab & Health Care	Champaign	Sullivan Health Care Center	Sullivan				25
26	Jonesboro Rehab & Health Care Center	Jonesboro	Sunset Manor Nursing Home	Canton				26
27	Kewanee Care Home	Kewanee	Swansea Rehab & Health Care	Swansea				27
28	Lebanon Care Center	Lebanon	Timbercreek Rehab & Health Center	Pekin				28
29	Marigold Rehab & Health Care Center	Galesburg	Toulon Health Care Center	Toulon				29
30			Tuscola Health Care Center	Tuscola				30

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Twin Lakes Rehab & Health Care Center	Paris	Cournerstone Health & Rehabiliation	Peoria				1
2	Vandalia Rehab & Health Care Center	Vandalia	Rock River Gardens	Sterling				2
3	Watseka Health Care Center	Watseka	Courtyard Estates of Farmington	Farmington				3
4	Westside Rehab & Care Center	West Frankfurt	Courtyard Estates of Knoxville	Knoxville				4
5	Whispering Oaks	Rosiclare	Betty's Garden	Kewanee				5
6	White Oak Rehab & Health Care Center	Mt. Vernon	Courtyard Estates of Green Valley	Green Valley				6
7	Willow Rose Rehab & Health Care Center	Jerseyville						7
8	Tuscola Health Care Center	Tuscola						8
9	Effingham Health Care Center	Effingham						9
10	Collinsville Health Care Center	Collinsville						10
11	Ozark Rehab & Health Care Center	Osage Beach, MO						11
12	Tarkio Rehab & Health Care Center	Tarkio, MO						12
13	Shangri-La Rehab & Living Center	Blue Springs, MO						13
14	Prairie Rose Care Center	Pana						14
15	Illini Hertiage Rehab & Health Center	Champaign						15
16	Courtyard Estates of Kewanee	Kewanee						16
17	Courtyard Estates of Bradford	Bradford						17
18	Courtyard Estates of Galva	Galva						18
19	Courtyard Estates of Walcott	Walcott						19
20	Courtyard Village of Kewanee	Kewanee						20
21	Lakewood Village	Charleston						21
22	Courtyard Estates of Monouth	Monmouth						22
23	Riverview Estates	Havana						23
24	Simple Blessing	Casey						24
25	Courtyard Estates of Bushnell	Bushnell						25
26	Courtyard Estates of Canton	Canton						26
27	Legacy Estates of Monmouth	Monmouth						27
28	Courtyard Estates of Sullivan	Sullivan						28
29	Courtyard Estates of Herscher	Herscher						29
30	Courtyard Estates of Girard	Girard						30

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		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	$		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 # 0055814 Report Period Beginning: 1/1/2025 Ending: 2/31/2025

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	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
2										2
3										3
4										4
5										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	TOTALS					$	$		$	25

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Tutera Investments & WCMC	X						508,893			11,688	6
7	Interest Income										(342)	7
8												8
9	TOTAL Facility Related						$	$ 508,893			$ 11,346	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 508,893			$ 11,346	15

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

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

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

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2024 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	15,494	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	23,077	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,583	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)	$	15,384	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	22,967	7

Assessed Value from Real Estate Tax Bill:	2024	19,435	8
Real Estate Tax Bill for Calendar Year:	2020	16,036	9
	2021	16,059	10
	2022	19,657	11
	2023	20,045	12
	2024	23,077	13

FOR BHF USE ONLY

14	FROM R. E. TAX STATEMENT FOR 2024	$	14
15	PLUS APPEAL COST FROM LINE 5	$	15
16	LESS REFUND FROM LINE 6	$	16
17	AMOUNT TO USE FOR RATE CALCULATION	$	17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cumberland Rehab Health CC COUNTY Cumberland

FACILITY IDPH LICENSE NUMBER 0055814

CONTACT PERSON REGARDING THIS REPORT Kiley Brooks

TELEPHONE (816) 444-0900 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-02-203-015	Long-Term Care Facility	$ 258.34	$ 258.34
2.	13-02-203-016	Long-Term Care Facility	$ 189.93	$ 189.93
3.	13-02-203-017	Long-Term Care Facility	$ 22,442.14	$ 22,442.14
4.	13-02-203-020	Long-Term Care Facility	$ 186.67	$ 186.67
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 23,077.08	$ 23,077.08

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

Facility Name & ID Numb Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,870 **B.** General Construction Type: Exterior Brick Frame Cement Block Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (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. List the bed capacity for the building if it differs from the licensed total. N/A

G. Have you properly capitalized all major repairs and equipment purchases? Yes

H. Are you presently operating under a sale and leaseback arrangement? No

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement? No

J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Long Term Care	328,878	2006	$	1
2					2
3	TOTALS	328,878		$	3

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		2006	1969	$	$	30	$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
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

*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 # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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)		$	$		$	$	$	70

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

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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	$ 13,956	$ 1,396	$ 1,396	$		$ 2,093	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 13,956	$ 1,396	$ 1,396	$		$ 2,093	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				$	$	$	$		$	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)	$ 13,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,396	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,396	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,093	85

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

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

G. Construction-in-Progress

	Description	Cost	
92	WIP - Reserves	$ 98,490	92
93			93
94			94
95		$ 98,490	95

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

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

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

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.	/2026	$
13.	/2027	$
14.	/2028	$

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 ☒ X NO

16. Rental Amount for movable equipment: $ 3,847 Description: Copier, dishwasher, medical equipment
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits
(c) For in-house training programs only. Do not include fringe benefits
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V39-03	hrs	$	2,521	$ 184,612	$	2,521	$ 184,612	1
2	Licensed Speech and Language Development Therapist	V39-02,03	hrs		35	4,667		35	4,667	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	V39-02,03	hrs		2,285	125,803	562	2,285	126,365	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	V39-02	# of prescrpts				51,611		51,611	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See WTB	V39-02,03				5,211	16,621		21,832	13
14	TOTAL			$	4,841	$ 320,293	$ 68,794	4,841	$ 389,087	14

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

Facility Name & ID Number Cumberland Rehab Health CC **#** 0055814 **Report Period Beginning:** 1/1/2025 **Ending:** 12/31/2025

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2025 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 37,263	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	297,853		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,255		6
7	Other Prepaid Expenses	27,826		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due to/from Related Party	14,992		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 380,189	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,956		16
17	Accumulated Depreciation (book methods)	(2,093)		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): WIP	98,490		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 110,353	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 490,542	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 316,901	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	508,893		29
30	Accrued Salaries Payable	(67,325)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,384		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to/from Related Party	305,301		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,079,154	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			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)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,079,154	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (588,612)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 490,542	$	48

***(See instructions.)**

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 149,876	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 149,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(738,487)	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) **rounding**	(1)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (738,488)	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)**	$ (588,612)	24 *

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

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,840,630	1
2	Discounts and Allowances for all Levels	(524,577)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,316,053	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	920,803	6
7	Oxygen	1,800	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 922,603	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	1	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	108,118	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	360	19
20	Radiology and X-Ray	8,950	20
21	Other Medical Services	2,809	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 120,238	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	342	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 342	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc. Revenue	31,449	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 31,449	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,390,685	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	653,301	31
32	Health Care	1,216,218	32
33	General Administration	1,504,173	33
	B. Capital Expense		
34	Ownership	140,059	34
	C. Ancillary Expense		
35	Special Cost Centers	416,854	35
36	Provider Participation Fee	198,567	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,129,172	40
41	**Income before Income Taxes (line 30 minus line 40)****	(738,487)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (738,487)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	$ 461,485.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	555,407.00	45
46	MMAI-Medicaid is the Primary Payer	228,485.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	970,168.00	48
49	Medicare Part A	296,728.00	49
50	Other-(specify)	-196,220.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,316,053	56

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,963	2,026	$ 87,530	$ 43.20	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,638	4,121	218,251	52.96	3
4	Licensed Practical Nurses	9,363	10,083	266,199	26.40	4
5	CNAs & Orderlies	18,974	20,153	471,375	23.39	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,287	1,351	23,146	17.13	9
10	Activity Assistants	575	607	8,665	14.28	10
11	Social Service Workers	1,602	1,826	30,745	16.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,841	10,384	172,299	16.59	15
16	Dishwashers					16
17	Maintenance Workers	2,035	2,186	42,608	19.49	17
18	Housekeepers	6,131	6,572	102,254	15.56	18
19	Laundry	2,414	2,522	39,779	15.77	19
20	Administrator	2,016	2,080	82,572	39.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,151	2,252	50,980	22.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	61,990	66,163	$ 1,596,403 *	$ 24.13	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	159	$ 8,434	V01-3	35
36	Medical Director	Monthly	17,400	V09-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,146	V10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	149	V11-3	44
45	Social Service Consultant	90	6,596	V12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	255	$ 35,725		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	313	$ 17,613	V10-3	50
51	Licensed Practical Nurses	134	7,337	V10-3	51
52	Certified Nurse Assistants/Aides	12	730	V10-3	52
53	TOTAL (lines 50 - 52)	459	$ 25,680		53

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rachel Green	Administrator	0	$ 82,572
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,572

B. Administrative - Other

Description	Amount
Tutera Health Care Services - Management Fee	$ 190,439
TOTAL (agree to Schedule V, line 17, col. 3)	$ 190,439
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Daniel Maher	Legal Fees	$ 1,153
Gutnicki LLP	Legal Fees	375
L'Hommedieu	Legal Fees	22,108
Scott & Kraus	Legal Fees	81,163
CLA	Accounting	6,261
Bluestar	Data Processing	366
Managed Energy	Data Processing	137
Mike Flanagan	Data Processing	60,000
Property Valuation	Data Processing	100
Transact Care	Data Processing	1,156
Wellsky	Data Processing	3,920
WALNUT CREEK MGMT CO LL	Accounting, DP, Prof Svcs	73,466
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 250,205

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	131,289
Employee Health Insurance	36,694
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	2,007
TOTAL (agree to Schedule V, line 22, col.8)	$ 169,990

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

Description	Line #	Amount
N/A		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,488
Health Care Worker Background Check	720
(Indicate # of checks performed)	
Patient Background Checks	
Association Dues (total from pg 22, #4)	
Other Dues	1,290
Other Licenses	3,449
IL Office of State Fire Marshall	
Less: Public Relations Expense	( )
PAC and Lobbying payments	( )
All non-allowable advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,947

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	6,354
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,354

**See instructions.

Facility Name & ID Number Cumberland Rehab Health CC # 0055814 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

XX. GENERAL INFORMATION:

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

(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below
Use the drop down list to identify the association.

Association Name	Amount
Total	

(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS
OR political action organizations
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1

Total	

(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

Total	

(5) Indicate the total amount of both disposable and non-disposable incontinent expens
and the location of this expense on Sch. V. $ **15,640** Line **10**

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

(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
during this cost report period. $ **198,567**
This amount is to be recorded on line 42 of Schedule V.

(8) 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.

(9) Have costs for all supplies and services which are of the type that can be billed t
the Department, in addition to the daily rate, been properly classifie
in the Ancillary Section of Schedule V' **Yes**

(10) 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.

(11) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset agains
related costs? **No** Indicate the amount. $

(12) 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. $ **N/A**

c. What percent of all travel expense relates to transportation of nurses and patients? **100%**

d. Have vehicle usage logs been maintained' **Yes**

e. Are all vehicles stored at the nursing home during the night and all othe
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? **N/A**

g. Does the facility transport residents to and from day training? **No**
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(13) Has an audit been performed by an independent certified public accounting firm **No**
Firm Name: **N/A**

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

(15) 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. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees