



Facility Name & ID Number Cumberland Rehab & Health Care Center

# 0050583 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,504	7,133	1,423	14,060	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,504	7,133	1,423	14,060	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.33%

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

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 1,285

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2017 Fiscal Year: 12/31/2017

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

Facility Name & ID Number Cumberland Rehab & Health Care Center # 0050583 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

**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
	<b>A. General Services</b>										
1	Dietary	111,120	9,652		120,772		120,772	3,156	123,928		1
2	Food Purchase		94,158		94,158		94,158	(3,129)	91,029		2
3	Housekeeping	71,358	13,675		85,033		85,033	47	85,080		3
4	Laundry	58	4,329		4,387		4,387		4,387		4
5	Heat and Other Utilities			61,475	61,475		61,475	166	61,641		5
6	Maintenance	32,251	7,683	15,535	55,469		55,469	263	55,732		6
7	Other (specify):* <u>Home Office Ben. Allocation</u>										7
8	<b>TOTAL General Services</b>	214,787	129,497	77,010	421,294		421,294	503	421,797		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	700,518	47,341	6,699	754,558		754,558	(2,432)	752,126		10
10a	Therapy		218	238,778	238,996		238,996		238,996		10a
11	Activities	22,952	113		23,065		23,065		23,065		11
12	Social Services	24,073			24,073		24,073	(9,713)	14,360		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Office Ben. Allocation</u>										15
16	<b>TOTAL Health Care and Programs</b>	747,543	47,672	258,677	1,053,892		1,053,892	(12,145)	1,041,747		16
	<b>C. General Administration</b>										
17	Administrative	10,631		192,600	203,231		203,231	(152,496)	50,735		17
18	Directors Fees										18
19	Professional Services			6,345	6,345		6,345	18,248	24,593		19
20	Dues, Fees, Subscriptions & Promotions			6,604	6,604		6,604	74	6,678		20
21	Clerical & General Office Expenses	27,578	2,294	8,987	38,859		38,859	33,966	72,825		21
22	Employee Benefits & Payroll Taxes			113,588	113,588		113,588	15,280	128,868		22
23	Inservice Training & Education							94	94		23
24	Travel and Seminar							47	47		24
25	Other Admin. Staff Transportation			2,808	2,808		2,808	2,262	5,070		25
26	Insurance-Prop.Liab.Malpractice			17,571	17,571		17,571	599	18,170		26
27	Other (specify):* <u>Home Office Ben. Allocation</u>										27
28	<b>TOTAL General Administration</b>	38,209	2,294	348,503	389,006		389,006	(81,926)	307,080		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,000,539	179,463	684,190	1,864,192		1,864,192	(93,568)	1,770,624		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 Care Center

#0050583

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			59,986	59,986		59,986	(1,202)	58,784			30
31	Amortization of Pre-Op. & Org.							7,111	7,111			31
32	Interest			59,300	59,300		59,300	13,387	72,687			32
33	Real Estate Taxes			16,634	16,634		16,634	181	16,815			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,172	10,172		10,172	959	11,131			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			146,092	146,092		146,092	20,436	166,528			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,626		24,626		24,626		24,626			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			106,672	106,672		106,672		106,672			42
43	Other (specify):*		48	19,317	19,365		19,365	(19,365)				43
44	<b>TOTAL Special Cost Centers</b>		24,674	125,989	150,663		150,663	(19,365)	131,298			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,000,539	204,137	956,271	2,160,947		2,160,947	(92,497)	2,068,450			45

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

**VI. ADJUSTMENT DETAIL**

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

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,143)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,511)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,311)	30		9
10	Interest and Other Investment Income	(400)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(191)	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	(8,581)	43		18
19	Entertainment				19
20	Contributions	(22)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(2,000)	43		24
25	Fund Raising, Advertising and Promotional	(1,411)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(18,071)	Various		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (45,641)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(75,781)	Various	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (75,781)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (121,422)		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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Cumberland Rehab & Health Care Center

ID# 0050583

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1	Labs-Part A	\$ (2,725)	43	1
2	X-Rays-Part A	(1,924)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(5)	21	3
4	Offset Transportation Revenue	(9,713)	11	4
5	Offset Miscellaneous Nursing Revenue	(2,476)	10	5
6	Offset Maintenance Expense	(1,228)	20	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
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45				45
46				46
47				47
48				48
49	<b>Total</b>	(18,071)		49

**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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	1 Dietary	\$	Petersen Health Care Management, Inc.	100.00%	\$ 3,156	\$ 3,156	1
2	V	2 Food		Petersen Health Care Management, Inc.	100.00%	14	14	2
3	V	3 Housekeeping		Petersen Health Care Management, Inc.	100.00%	47	47	3
4	V	5 Utilities		Petersen Health Care Management, Inc.	100.00%	166	166	4
5	V	6 Maintenance		Petersen Health Care Management, Inc.	100.00%	1,491	1,491	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%	44	44	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	192,600	Petersen Health Care Management, Inc.	100.00%	40,104	(152,496)	11
12	V	19 Professional Services		Petersen Health Care Management, Inc.	100.00%	9,885	9,885	12
13	V							13
14	Total		\$ 192,600			\$ 54,907	\$ * (137,693)	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%	\$ 74	\$	74	15
16	V	21 Clerical and General Office		Petersen Health Care Management, Inc.	100.00%	33,971		33,971	16
17	V	22 Employee Benefits and Payroll Taxes		Petersen Health Care Management, Inc.	100.00%	15,280		15,280	17
18	V	23 Inservice Training & Education		Petersen Health Care Management, Inc.	100.00%	94		94	18
19	V	24 Travel and Seminar		Petersen Health Care Management, Inc.	100.00%	47		47	19
20	V	25 Other Admin. Staff Transport.		Petersen Health Care Management, Inc.	100.00%	2,262		2,262	20
21	V	26 Insurance-Prop./Liab./Malprac.		Petersen Health Care Management, Inc.	100.00%	599		599	21
22	V	27 Mgmt. Allocation of Benefits		Petersen Health Care Management, Inc.	100.00%	8,090		8,090	22
23	V	30 Depreciation		Petersen Health Care Management, Inc.	100.00%	73		73	23
24	V	32 Interest		Petersen Health Care Management, Inc.	100.00%	263		263	24
25	V	33 Real Estate Taxes		Petersen Health Care Management, Inc.	100.00%	181		181	25
26	V	35 Rent-Equipment & Vehicles		Petersen Health Care Management, Inc.	100.00%	959		959	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		\$			\$ 61,893	\$ *	61,893	39

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



VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1 Dietary	\$	Petersen Health 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%	0		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%	19	19	33
34	V	31 Amortization		Petersen Health Network, LLC	100.00%	0		34
35	V	32 Interest		Petersen Health Network, LLC	100.00%	0		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	\$ *	19

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

Facility Name &amp; ID Number

Cumberland Rehab &amp; Health Care Center

# 0050583

Report Period Beginning:

1/1/2017

Ending: 12/31/2017

## 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 System	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	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 Busine	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 &amp; ID Number

Cumberland Rehab &amp; Health Care Center

# 0050583

Report Period Beginning:

1/1/2017

Ending:

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## 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

VII. RELATED PARTIES

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

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



Facility Name & ID Number Cumberland Rehab & Health Care Center # 0050583 Report Period Beginning: 1/1/2017 Ending: 12/31/2017

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											3
4	N/A										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 Care Center# 0050583

Report Period Beginning:

1/1/2017Ending: 2/31/2017

## VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care Management, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

( 309) 691-8113

Fax Number

( 309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,451,714	75	\$ 325,901	\$ 376,129	14,060	\$ 3,156	1
2	2	Food	Resident Days	1,451,714	75	1,404	0	14,060	14	2
3	3	Housekeeping	Resident Days	1,451,714	75	4,904	2,743	14,060	47	3
4	5	Utilities	Resident Days	1,451,714	75	17,131	0	14,060	166	4
5	6	Maintenance	Resident Days	1,451,714	75	153,997	146,594	14,060	1,491	5
6	7	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	14,060	0	6
7	9	Medical Director	Resident Days	1,451,714	75	0	0	14,060	0	7
8	10	Nursing and Medical Records	Resident Days	1,451,714	75	4,528	1,833,909	14,060	44	8
9	10A	Therapy	Resident Days	1,451,714	75	0	0	14,060	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,451,714	75	0	0	14,060	0	10
11	17	Administrative	Resident Days	1,451,714	75	4,871,788	5,558,349	14,060	40,104	11
12	19	Professional Services	Resident Days	1,451,714	75	1,020,623	0	14,060	9,885	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,451,714	75	7,613	0	14,060	74	13
14	21	Clerical and General Office	Resident Days	1,451,714	75	3,507,569	3,782,761	14,060	33,971	14
15	22	Employee Benefits and Payroll Ta	Resident Days	1,451,714	75	1,577,706	0	14,060	15,280	15
16	23	Inservice Training & Education	Resident Days	1,451,714	75	9,731	0	14,060	94	16
17	24	Travel and Seminar	Resident Days	1,451,714	75	4,833	0	14,060	47	17
18	25	Other Admin. Staff Transport.	Resident Days	1,451,714	75	233,560	0	14,060	2,262	18
19	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,451,714	75	61,886	0	14,060	599	19
20	30	Depreciation	Resident Days	1,451,714	75	835,302	0	14,060	8,090	20
21	31	Amortization	Resident Days	1,451,714	75	7,526	0	14,060	73	21
22	32	Interest	Resident Days	1,451,714	75	27,155	0	14,060	263	22
23	33	Real Estate Taxes	Resident Days	1,451,714	75	18,716	0	14,060	181	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,451,714	75	99,030	0	14,060	959	24
25	TOTALS					\$ 12,790,903	\$ 11,700,485		\$ 116,800	25

Facility Name & ID Number Cumberland Rehab & Health Care Center # 0050583 Report Period Beginning: 1/1/2017 Ending: 2/31/2017

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization Petersen Health 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	241,133	13	\$	14,060	\$	1
2	2	Food	Resident Days	241,133	13		14,060		2
3	3	Housekeeping	Resident Days	241,133	13		14,060		3
4	4	Laundry	Resident Days	241,133	13		14,060		4
5	5	Utilities	Resident Days	241,133	13		14,060		5
6	6	Maintenance	Resident Days	241,133	13		14,060		6
7	7	Mgmt. Allocation of Benefits	Resident Days	241,133	13		14,060		7
8	10	Nursing and Medical Records	Resident Days	241,133	13		14,060		8
9	15	Mgmt. Allocation of Benefits	Resident Days	241,133	13		14,060		9
10	17	Administrative	Resident Days	241,133	13		14,060		10
11	19	Professional Services	Resident Days	241,133	13		14,060		11
12	20	Dues, Fees, Subs & Promotions	Resident Days	241,133	13		14,060		12
13	21	Clerical and General Office	Resident Days	241,133	13		14,060		13
14	22	Employee Benefits & Payroll	Resident Days	241,133	13		14,060		14
15	23	Inservice Training & Education	Resident Days	241,133	13		14,060		15
16	24	Travel and Seminar	Resident Days	241,133	13		14,060		16
17	25	Other Admin. Staff Transport.	Resident Days	241,133	13		14,060		17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	241,133	13		14,060		18
19	30	Depreciation	Resident Days	241,133	13		14,060	19	19
20	31	Amortization	Resident Days	241,133	13		14,060		20
21	32	Interest	Resident Days	241,133	13		14,060		21
22	33	Real Estate Taxes	Resident Days	241,133	13		14,060		22
23	34	Rent-Facility and Grounds	Resident Days	241,133	13		14,060		23
24	35	Rent-Equipment & Vehicles	Resident Days	241,133	13		14,060		24
25	TOTALS					\$	\$	\$	19



Facility Name & ID Number Cumberland Rehab & Health Care Center

# 0050583

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Wells Fargo		X	Mortgage	Varies	1/1/2015	\$ 1,171,744	\$ 1,026,786	12/31/2034	Varies	\$ 59,300	1						
2												2						
3												3						
4												4						
5												5						
<b>Working Capital</b>																		
6												6						
7												7						
8												8						
9	<b>TOTAL Facility Related</b>						\$ 1,171,744	\$ 1,026,786			\$ 59,300	9						
<b>B. Non-Facility Related*</b>																		
10									Interest Income Offset		(400)	10						
11									Home Office Allocation-PHN		263	11						
12									Home Office Allocation-PHCM		13,524	12						
13												13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ 13,387	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 1,171,744	\$ 1,026,786			\$ 72,687	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**

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

1. Real Estate Tax accrual used on 2016 report.		\$	<b>18,396</b>	<b>1</b>
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.)		\$	<b>17,258</b>	<b>2</b>
3. Under or (over) accrual (line 2 minus line 1).		\$	<b>(1,138)</b>	<b>3</b>
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<b>17,772</b>	<b>4</b>
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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$		<b>5</b>
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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	<b>Home Office Allocation</b>	\$	<b>181</b>	<b>6</b>
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	<b>16,815</b>	<b>7</b>

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	<b>2012</b>	<b>16,774</b>	<b>8</b>
	<b>2013</b>	<b>16,544</b>	<b>9</b>
	<b>2014</b>	<b>16,651</b>	<b>10</b>
	<b>2015</b>	<b>17,864</b>	<b>11</b>
	<b>2016</b>	<b>17,258</b>	<b>12</b>

**Accrual based on prior year tax bill.**

<b>FOR BHF USE ONLY</b>			
<b>13</b>	FROM R. E. TAX STATEMENT FOR 2016	\$	<b>13</b>
<b>14</b>	PLUS APPEAL COST FROM LINE 5	\$	<b>14</b>
<b>15</b>	LESS REFUND FROM LINE 6	\$	<b>15</b>
<b>16</b>	AMOUNT TO USE FOR RATE CALCULATION	\$	<b>16</b>

**NOTES:**

- Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
- 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.**

# 2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cumberland Rehab & Health Care Center 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 2016 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 2016.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>13-02-203-015</u>	<u>Long-Term Care Facility</u>	\$ <u>86.60</u>	\$ <u>86.60</u>
2.	<u>13-02-203-016</u>	<u>Long-Term Care Facility</u>	\$ <u>46.04</u>	\$ <u>46.04</u>
3.	<u>13-02-203-017</u>	<u>Long-Term Care Facility</u>	\$ <u>16,957.42</u>	\$ <u>16,957.42</u>
4.	<u>13-02-203-020</u>	<u>Long-Term Care Facility</u>	\$ <u>167.56</u>	\$ <u>167.56</u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>			\$ <u><u>17,257.62</u></u>	\$ <u><u>17,257.62</u></u>

**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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 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 grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: 561,304 2. Number of Years Over Which it is Being Amortized: 20 3. Current Period Amortization: 7,111 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.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 328,878, 2006, \$ 140,000, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 328,878, (blank), \$ 140,000, 3.

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	\$ 34,053	\$ 444,669
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	3,150
11	Dry valve replacement		2008	3,653		15	244	244	2,318
12	Wall Repair		2012	11,730		15	782	782	4,301
13	Furnaces		2013	5,345		15	356	356	1,602
14	Vinyl Plank Flooring in Common Area		2014	4,930		15	329	329	1,152
15	Parking Lot Paving		2015	32,500		15	2,168	2,168	5,420
16	Remodeling of 4 Medicare Rooms-Painting, Flooring, Bedding		2016	13,100		10	1,310	1,310	1,965
17	Concrete Sidewalk Replacement		2016	22,092		15	1,472	1,472	2,208
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				7,193			(7,193)	
33									
34	2017-Home Office Allocation-Building Improvements			6,431			154	154	
35	2017-Home Office Allocation-Land Improvements			592			38	38	
36									

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,268,368	\$ 54,375		\$ 45,820	\$ (13,169)	\$ 480,280	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	\$ 39,227	\$ 3,187	\$ 3,835	\$ 648	5-10 yrs.	\$ 21,582	71
72	Current Year Purchases	16,964	2,424	1,212	(1,212)	7 yrs.	1,212	72
73	Fully Depreciated Assets	204,346					204,346	73
74	Home Office Allocation			7,917	7,917			74
75	TOTALS	\$ 260,537	\$ 5,611	\$ 12,964	\$ 7,353		\$ 227,140	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	76
77										77
78										78
79										79
80	TOTALS			\$ 28,328	\$	\$	\$		\$ 28,328	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)	\$ 1,697,233	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 59,986	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 58,784	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (1,202)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 735,748	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	N/A				89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

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	<b>TOTAL</b>				\$			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. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2019 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2020 \$ \_\_\_\_\_

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: \$ 11,131 Description: See Attached Schedule 14A

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	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 Care Center  
0050583**

**Period Beginning**      1/1/2017  
**Period End**              12/31/2017

**Schedule 14A**

**XII. Rental Costs**

**B. Equipment**

**16. Description of rental amount for movable equipment**

Medical Equipment	\$	3,443
Dishwasher		1,020
Generator		19
Copier		5,690
Home Office Allocation		959
		<u>11,131</u>

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	5,875	\$ 88,124	\$	5,875	\$ 88,124	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,521	37,818		2,521	37,818	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(2), 10A(3)	hrs		7,522	112,836	218	7,522	113,054	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescripts				24,626		24,626	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	<b>TOTAL</b>			\$	15,918	\$ 238,778	\$ 24,844	15,918	\$ 263,622	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 Care Center# 0050583Report Period Beginning: 1/1/2017Ending: 12/31/2017

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2017

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 2,008,773	\$ 2,008,773	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>98,172</u> )	428,652	428,652	3
4	Supply Inventory (priced at <u>Cost</u> )	7,083	7,083	4
5	Short-Term Investments			5
6	Prepaid Insurance	12,013	12,013	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Employee Education Loans</u>	1,114	1,114	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,457,635	\$ 2,457,635	10
	<b>B. Long-Term Assets</b>			
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	1,156,431	14
15	Leasehold Improvements, at Historical Cost	110,055	111,937	15
16	Equipment, at Historical Cost	288,865	288,865	16
17	Accumulated Depreciation (book methods)	(824,644)	(735,748)	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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 878,008	\$ 961,485	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,335,643	\$ 3,419,120	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 502,891	\$ 502,891	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	49,446	49,446	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,886	1,886	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,772	17,772	32
33	Accrued Interest Payable	5,185	5,185	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Payroll Withholdings</u>	25,220	25,220	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 602,400	\$ 602,400	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,026,786	1,026,786	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,026,786	\$ 1,026,786	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,629,186	\$ 1,629,186	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,706,457	\$ 1,789,934	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,335,643	\$ 3,419,120	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>1,399,441</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Adjustments Made After Cost Reports Filed</b>	<b>8,124</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,407,565</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>298,892</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>298,892</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,706,457</b>	<b>24</b> *

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

Facility Name &amp; ID Number Cumberland Rehab &amp; Health Care Center

# 0050583

Report Period Beginning: 1/1/2017

Ending: 12/31/2017

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,129,553	1
2	Discounts and Allowances for all Levels	(178,452)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,951,101	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	444,026	6
7	Oxygen	473	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 444,499	8
<b>C. Other Operating Revenue</b>			
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	3,143	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	40,776	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,575	20
21	Other Medical Services	1,923	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 50,417	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	400	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 400	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Transportation Revenue</u>	9,713	28
28a	<u>Miscellaneous Revenue</u>	3,709	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,422	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,459,839	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	421,294	31
32	Health Care	1,053,892	32
33	General Administration	389,006	33
<b>B. Capital Expense</b>			
34	Ownership	146,092	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	43,991	35
36	Provider Participation Fee	106,672	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,160,947	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	298,892	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 298,892	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 720,554	44
45	Private Pay - Net Inpatient Revenue	955,068	45
46	Medicare - Net Inpatient Revenue	231,505	46
47	Other-(specify) <u>Insurance Net Inpatient Revenue</u>	43,974	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 1,951,101	49

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

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

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

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

Facility Name & ID Number Cumberland Rehab & Health Care Center

# 0050583

Report Period Beginning:

1/1/2017

Ending:

12/31/2017

**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	\$ 62,724	\$ 30.16	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,515	5,867	132,546	22.59	3
4	Licensed Practical Nurses	9,608	9,749	198,540	20.37	4
5	CNAs & Orderlies	25,371	25,942	261,091	10.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,561	1,561	22,952	14.70	9
10	Activity Assistants					10
11	Social Service Workers	1,571	1,731	24,073	13.91	11
12	Dietician					12
13	Food Service Supervisor	2,345	2,352	36,375	15.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,999	8,152	74,745	9.17	15
16	Dishwashers					16
17	Maintenance Workers	1,939	2,095	32,251	15.39	17
18	Housekeepers	5,881	6,084	71,358	11.73	18
19	Laundry	6	6	58	9.67	19
20	Administrator	2,080	2,080	40,104	19.28	20
21	Assistant Administrator	883	922	10,631	11.53	21
22	Other Administrative					22
23	Office Manager	2,028	2,106	27,578	13.09	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) <u>CPC</u>	1,931	2,085	45,617	21.88	33
34	TOTAL (lines 1 - 33)	70,798	72,812	\$ 1,040,643 *	\$ 14.29	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 3,682	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 \$ 16,998		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

**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	\$ 13,542	Workers' Compensation Insurance	\$ 18,927	IDPH License Fee	\$ 3,980			
Rachel Green	Administrator	0	37,193	Unemployment Compensation Insurance	17,765	Advertising: Employee Recruitment				
				FICA Taxes	75,545	Health Care Worker Background Check (Indicate # of checks performed <u>186</u> )	1,352			
				Employee Health Insurance	453	Patient Background Checks				
				Employee Meals		Miscellaneous Licenses & Permits	295			
				Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous Dues & Subscriptions	977			
				Employee Relations	721	Home Office Allocation	74			
				Employee Retirement	177					
				Home Office Allocation	15,280					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 50,735	TOTAL (agree to Schedule V, line 22, col.8)			\$ 128,868	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,678
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			\$ 192,600				Out-of-State Travel	\$		
							In-State Travel			
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 192,600				Seminar Expense			
C. Professional Services				TOTAL			\$	Home Office Allocation	47	
Vendor/Payee	Type		Amount				Entertainment Expense (agree to Sch. V, line 24, col. 8)			
Mediacom	Computer Services		1,639				TOTAL		\$ 47	
Allscripts	Computer Services		888							
Ability Network	Computer Services		3,818							
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 6,345							

\* Attach copy of IMRF notifications

\*\*See instructions.



**Cumberland Rehab & Health Care Center****0050583****Period Beginning****1/1/2017****Period End****12/31/2017****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services**

<b>Vendor/Payee</b>	<b>Type</b>	<b>Amount</b>
Total (agree to Schedule V, line 19, column 3)		6,345
<b>Home Office Allocation</b>		
MusilloUnkenholt, LLC	Legal	113
Arnstein & Lehr	Legal	759
SB2	Legal	477
Miscellaneous	Legal	9
Miller Hall and Triggs	Legal	121
Smith Amundsen	Legal	47
Healthcare Resources International	Legal	84
Hunziker Law	Legal	1
Lexis Nexis	Legal	5
Baker Tilly Virchow Krause	Legal	424
Secretary of State	Legal	102
Wells Fargo	Legal	199
CliftonLarsonAllen	Accounting	1356
Ginoli & Co.	Accounting	1944
Baker Tilly Virchow Krause	Accounting	85
Wells Fargo	Accounting	2261
Miscellaneous	Computer Services	62
Change Healthcare	Computer Services	5
360 Networks	Computer Services	26
Matrix Care	Computer Services	2366
Stratus Networks	Computer Services	282
Kemper Technology	Computer Services	160
AT&T	Computer Services	4
Ability Network	Computer Services	174
CIAN	Computer Services	197
Comcast	Computer Services	11
CCH	Computer Services	10
Charter Communications	Computer Services	20
Allscripts	Computer Services	175
ATS	Computer Services	180
Citrix Systems	Computer Services	17
Optimizer	Other Prof Fees	32
Ankura	Other Prof Fees	509
David Budde	Other Prof Fees	24
Sargent Consulting	Other Prof Fees	5539
Alix Partners	Other Prof Fees	344
Demonica Kemper	Other Prof Fees	21
Brad Barkley	Other Prof Fees	83
MPAC Healthcare	Other Prof Fees	12
Higgs Appraisal	Other Prof Fees	6
Alan Litwiller	Other Prof Fees	2
Total (agree to Schedule V, line 19, column 8)		<u><u>24,593</u></u>

Facility Name & ID Number Cumberland Rehab & Health Care Center# 0050583

Report Period Beginning:

1/1/2017

Ending:

12/31/2017**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IHCA-\$952
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 16,488 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 106,672  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,143
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 9,081  
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? Yes  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 632
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Ginoli and Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. No  
Attach invoices and a summary of services for all architect and appraisal fees