

Facility Name & ID Number Cumberland Rehab & Health Care Center

0048603 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	7,519	3,880	390	11,789	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,519	3,880	390	11,789	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.81%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

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

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

YES

NO

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

Date started 09/22/2006

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

YES

Date 09/22/2006

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 390

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: 12/31/2007 Fiscal Year: 12/31/2007

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

Facility Name & ID Number Cumberland Rehab & Health Care Center # 0048603 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	88,639	8,177		96,816		96,816	987	97,803		1
2	Food Purchase		64,483		64,483		64,483	(3,424)	61,059		2
3	Housekeeping	45,922	14,560		60,482		60,482	16	60,498		3
4	Laundry	19,646	9,049		28,695		28,695	1	28,696		4
5	Heat and Other Utilities			55,097	55,097		55,097	168	55,265		5
6	Maintenance	28,004	9,427	22,030	59,461		59,461	1,442	60,903		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							450	450		7
8	TOTAL General Services	182,211	105,696	77,127	365,034		365,034	(360)	364,674		8
	B. Health Care and Programs										
9	Medical Director			10,700	10,700		10,700		10,700		9
10	Nursing and Medical Records	496,414	26,478	630	523,522		523,522	2,620	526,142		10
10a	Therapy			31,693	31,693		31,693		31,693		10a
11	Activities	18,971	932	597	20,500		20,500		20,500		11
12	Social Services	22,829			22,829		22,829		22,829		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							580	580		15
16	TOTAL Health Care and Programs	538,214	27,410	43,620	609,244		609,244	3,200	612,444		16
	C. General Administration										
17	Administrative	57,415		37,000	94,415		94,415	(29,656)	64,759		17
18	Directors Fees										18
19	Professional Services			3,656	3,656		3,656	2,690	6,346		19
20	Dues, Fees, Subscriptions & Promotions			2,659	2,659		2,659	432	3,091		20
21	Clerical & General Office Expenses	1,441	3,609	13,375	18,425		18,425	17,996	36,421		21
22	Employee Benefits & Payroll Taxes			104,963	104,963		104,963		104,963		22
23	Inservice Training & Education			107	107		107	212	319		23
24	Travel and Seminar							306	306		24
25	Other Admin. Staff Transportation			3,870	3,870		3,870	1,174	5,044		25
26	Insurance-Prop.Liab.Malpractice			15,640	15,640		15,640	522	16,162		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							4,781	4,781		27
28	TOTAL General Administration	58,856	3,609	181,270	243,735		243,735	(1,543)	242,192		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	779,281	136,715	302,017	1,218,013		1,218,013	1,297	1,219,310		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

#0048603

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			80,187	80,187		80,187	(15,066)	65,121			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			99,388	99,388		99,388	4,277	103,665			32
33	Real Estate Taxes			29,391	29,391		29,391	386	29,777			33
34	Rent-Facility & Grounds							24	24			34
35	Rent-Equipment & Vehicles			5,097	5,097		5,097	311	5,408			35
36	Other (specify):*											36
37	TOTAL Ownership			214,063	214,063		214,063	(10,068)	203,995			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		9,282		9,282		9,282		9,282			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			25,929	25,929		25,929		25,929			42
43	Other (specify):* Non-allowable Cost		217	20,936	21,153		21,153	(21,153)				43
44	TOTAL Special Cost Centers		9,499	46,865	56,364		56,364	(21,153)	35,211			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	779,281	146,214	562,945	1,488,440		1,488,440	(29,924)	1,458,516			45

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

**See schedule of adjustments attached at end of cost report.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,458)	2		4
5	Telephone, TV & Radio in Resident Rooms	(710)	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	(16,430)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(579)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,181)	43		24
25	Fund Raising, Advertising and Promotional	(7,408)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Pg. 5A	(505)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (41,271)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	11,347	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 11,347		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (29,924)		37

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

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

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

Cumberland Rehab & Health Care Center

ID# 0048603

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (75)	43	1
2	X-Rays-Part A	(200)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(230)	21	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				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	(505)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Cumberland Rehab & Health Care Center# 0048603

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	987	0	0	0	0	0	0	0	0	0	987	1
2	Food Purchase	(3,458)	34	0	0	0	0	0	0	0	0	0	(3,424)	2
3	Housekeeping	0	11	0	5	0	0	0	0	0	0	0	16	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	0	168	0	0	0	0	0	0	0	0	0	168	5
6	Maintenance	0	1,374	0	68	0	0	0	0	0	0	0	1,442	6
7	Other (specify):*	0	450	0	0	0	0	0	0	0	0	0	450	7
8	TOTAL General Services	(3,458)	3,025	0	73	0	(360)	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	2,608	0	12	0	0	0	0	0	0	0	2,620	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	580	0	0	0	0	0	0	0	0	0	580	15
16	TOTAL Health Care and Programs	0	3,188	0	12	0	3,200	16						
	C. General Administration													
17	Administrative	0	(29,656)	0	0	0	0	0	0	0	0	0	(29,656)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,994	0	696	0	0	0	0	0	0	0	2,690	19
20	Fees, Subscriptions & Promotions	0	0	432	0	0	0	0	0	0	0	0	432	20
21	Clerical & General Office Expenses	(230)	0	16,722	1,504	0	0	0	0	0	0	0	17,996	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	192	20	0	0	0	0	0	0	0	212	23
24	Travel and Seminar	0	0	306	0	0	0	0	0	0	0	0	306	24
25	Other Admin. Staff Transportation	0	0	1,109	65	0	0	0	0	0	0	0	1,174	25
26	Insurance-Prop.Liab.Malpractice	0	0	452	70	0	0	0	0	0	0	0	522	26
27	Other (specify):*	0	0	4,781	0	0	0	0	0	0	0	0	4,781	27
28	TOTAL General Administration	(230)	(27,662)	23,994	2,355	0	(1,543)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(3,688)	(21,449)	23,994	2,440	0	1,297	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Cumberland Rehab & Health Care Center # 0048603 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(16,430)	0	1,171	193	0	0	0	0	0	0	0	(15,066)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	2,035	2,242	0	0	0	0	0	0	0	4,277	32
33	Real Estate Taxes	0	0	386	0	0	0	0	0	0	0	0	386	33
34	Rent-Facility & Grounds	0	0	24	0	0	0	0	0	0	0	0	24	34
35	Rent-Equipment & Vehicles	0	0	311	0	0	0	0	0	0	0	0	311	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(16,430)	0	3,927	2,435	0	(10,068)	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):*	(21,153)	0	0	0	0	0	0	0	0	0	0	(21,153)	43
44	TOTAL Special Cost Centers	(21,153)	0	0	0	0	0	0	0	0	0	0	(21,153)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(41,271)	(21,449)	27,921	4,875	0	(29,924)	45						

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: 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, Inc.	100.00%	\$ 987	\$ 987	1
2	V	2 Food		Petersen Health Care, Inc.	100.00%	34	34	2
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	11	11	3
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	168	168	5
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,374	1,374	6
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	450	450	7
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	2,608	2,608	8
9	V	10A Therapy		Petersen Health Care, Inc.	100.00%	0		9
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	580	580	10
11	V	17 Administrative	37,000	Petersen Health Care, Inc.	100.00%	7,344	(29,656)	11
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	1,994	1,994	12
13	V							13
14	Total		\$ 37,000			\$ 15,551	\$ * (21,449)	14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	20 Dues, Fees, Subs and Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 432	\$	432	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	16,722		16,722	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	192		192	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	306		306	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,109		1,109	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	452		452	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	4,781		4,781	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	1,171		1,171	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	2,035		2,035	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	386		386	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	24		24	25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	311		311	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		\$			\$ 27,921	\$ *	27,921	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	<u>1</u> Dietary	\$	Petersen Companies, LLC	100.00%	\$ 0	\$ 0
16	V	<u>2</u> Food		Petersen Companies, LLC	100.00%	0	0
17	V	<u>3</u> Housekeeping		Petersen Companies, LLC	100.00%	5	5
18	V	<u>4</u> Laundry		Petersen Companies, LLC	100.00%	0	0
19	V	<u>5</u> Utilities		Petersen Companies, LLC	100.00%	0	0
20	V	<u>6</u> Maintenance		Petersen Companies, LLC	100.00%	68	68
21	V	<u>7</u> Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0
22	V	<u>10</u> Nursing and Medical Records		Petersen Companies, LLC	100.00%	12	12
23	V	<u>10A</u> Therapy		Petersen Companies, LLC	100.00%	0	0
24	V	<u>15</u> Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0
25	V	<u>17</u> Administrative		Petersen Companies, LLC	100.00%	0	0
26	V	<u>19</u> Professional Services		Petersen Companies, LLC	100.00%	696	696
27	V	<u>20</u> Dues, Fees, Subs and Promotions		Petersen Companies, LLC	100.00%	0	0
28	V	<u>21</u> Clerical and General Office		Petersen Companies, LLC	100.00%	1,504	1,504
29	V	<u>23</u> Inservice Training and Education		Petersen Companies, LLC	100.00%	20	20
30	V	<u>24</u> Travel and Seminar		Petersen Companies, LLC	100.00%	0	0
31	V	<u>25</u> Other Admin. Staff Transportation		Petersen Companies, LLC	100.00%	65	65
32	V	<u>26</u> Insurance-Prop./Liab/Malpractice		Petersen Companies, LLC	100.00%	70	70
33	V	<u>27</u> Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0	0
34	V	<u>30</u> Depreciation		Petersen Companies, LLC	100.00%	193	193
35	V	<u>32</u> Interest		Petersen Companies, LLC	100.00%	2,242	2,242
36	V	<u>33</u> Real Estate Taxes		Petersen Companies, LLC	100.00%	0	0
37	V	<u>34</u> Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0	0
38	V	<u>35</u> Rent-Equipment and Vehicles		Petersen Companies, LLC	100.00%	0	0
39	Total		\$			\$ 4,875	\$ * 4,875

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

Facility Name & ID Number Cumberland Rehab & Health Care Center # 0048603 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	See Schedule 7A	0.48	0.88	Salary	\$ 7,344	L17, C7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 7,344		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# 0048603

Report Period Beginning:

01/01/2007Ending: 12/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	1	Dietary	Resident Days	1,316,550	66	\$ 110,171	\$ 109,587	11,789	\$ 987	1
2	2	Food	Resident Days	1,316,550	66	3,806	0	11,789	34	2
3	3	Housekeeping	Resident Days	1,316,550	66	1,250	0	11,789	11	3
4	4	Laundry	Resident Days	1,316,550	66	73	0	11,789	1	4
5	5	Utilities	Resident Days	1,316,550	66	18,812	0	11,789	168	5
6	6	Maintenance	Resident Days	1,316,550	66	153,468	113,063	11,789	1,374	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	50,271	0	11,789	450	7
8	10	Nursing and Medical Records	Resident Days	1,316,550	66	291,305	286,855	11,789	2,608	8
9	10A	Therapy	Resident Days	1,316,550	66	0	0	11,789	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	64,765	0	11,789	580	10
11	17	Administrative	Resident Days	1,316,550	66	820,116	820,116	11,789	7,344	11
12	19	Professional Services	Resident Days	1,316,550	66	222,628	0	11,789	1,994	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,316,550	66	48,243	0	11,789	432	13
14	21	Clerical and General Office	Resident Days	1,316,550	66	1,867,440	1,544,801	11,789	16,722	14
15	23	Inservice Training & Education	Resident Days	1,316,550	66	21,481	0	11,789	192	15
16	24	Travel and Seminar	Resident Days	1,316,550	66	34,177	0	11,789	306	16
17	25	Other Admin. Staff Transport.	Resident Days	1,316,550	66	123,847	0	11,789	1,109	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,316,550	66	50,427	0	11,789	452	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,316,550	66	533,953	0	11,789	4,781	19
20	30	Depreciation	Resident Days	1,316,550	66	130,767	0	11,789	1,171	20
21	32	Interest	Resident Days	1,316,550	66	227,295	0	11,789	2,035	21
22	33	Real Estate Taxes	Resident Days	1,316,550	66	43,090	0	11,789	386	22
23	34	Rent-Facility and Grounds	Resident Days	1,316,550	66	2,648	0	11,789	24	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,316,550	66	34,690	0	11,789	311	24
25	TOTALS					\$ 4,854,723	\$ 2,874,422		\$ 43,472	25

Facility Name & ID Number Cumberland Rehab & Health Care Center# 0048603

Report Period Beginning:

01/01/2007Ending: 12/31/2007

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 Companies, 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	179,368	12	\$	11,789	\$	1
2	2	Food	Resident Days	179,368	12		11,789		2
3	3	Housekeeping	Resident Days	179,368	12	70	11,789	5	3
4	4	Laundry	Resident Days	179,368	12		11,789		4
5	5	Utilities	Resident Days	179,368	12		11,789		5
6	6	Maintenance	Resident Days	179,368	12	1,038	11,789	68	6
7	7	Mgmt. Allocation of Benefits	Resident Days	179,368	12		11,789		7
8	10	Nursing and Medical Records	Resident Days	179,368	12	189	11,789	12	8
9	10A	Therapy	Resident Days	179,368	12		11,789		9
10	15	Mgmt. Allocation of Benefits	Resident Days	179,368	12		11,789		10
11	17	Administrative	Resident Days	179,368	12		11,789		11
12	19	Professional Services	Resident Days	179,368	12	10,592	11,789	696	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	179,368	12		11,789		13
14	21	Clerical and General Office	Resident Days	179,368	12	22,877	11,789	1,504	14
15	23	Inservice Training & Education	Resident Days	179,368	12	300	11,789	20	15
16	24	Travel and Seminar	Resident Days	179,368	12		11,789		16
17	25	Other Admin. Staff Transport.	Resident Days	179,368	12	993	11,789	65	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	179,368	12	1,070	11,789	70	18
19	27	Mgmt. Allocation of Benefits	Resident Days	179,368	12		11,789		19
20	30	Depreciation	Resident Days	179,368	12	2,941	11,789	193	20
21	32	Interest	Resident Days	179,368	12	34,114	11,789	2,242	21
22	33	Real Estate Taxes	Resident Days	179,368	12		11,789		22
23	34	Rent-Facility and Grounds	Resident Days	179,368	12		11,789		23
24	35	Rent-Equipment & Vehicles	Resident Days	179,368	12		11,789		24
25	TOTALS					\$ 74,184	\$	\$ 4,875	25

Facility Name & ID Number Cumberland Rehab & Health Care Center

0048603

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	LaSalle Bank		X	Mortgage	Varies	10/31/07	\$ 1,120,000	\$ 1,115,968	10/31/12	Varies	\$ 92,802	1								
2	Associated Bank		X	Vehicle	\$579.98	07/23/07	28,328	26,375	07/23/12	0.0828	947	2								
3												3								
4							Home Office Allocation				4,277	4								
5							Amortization Expense				5,639	5								
Working Capital																				
6												6								
7												7								
8												8								
9	TOTAL Facility Related				\$579.98		\$ 1,148,328	\$ 1,142,343			\$ 103,665	9								
B. Non-Facility Related*																				
10												10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$	14								
15	TOTALS (line 9+line14)						\$ 1,148,328	\$ 1,142,343			\$ 103,665	15								

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Cumberland Rehab & Health Care Center COUNTY Cumberland

FACILITY IDPH LICENSE NUMBER 0048603

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(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>13-02-203-017</u>	<u>Long-Term Care Facility</u>	\$ <u>14,293.36</u>	\$ <u>14,293.36</u>
2. <u>13-02-203-015</u>	<u>Long-Term Care Facility</u>	\$ <u>37.18</u>	\$ <u>37.18</u>
3. <u>13-02-203-016</u>	<u>Long-Term Care Facility</u>	\$ <u>11.32</u>	\$ <u>11.32</u>
4. <u>13-02-203-020</u>	<u>Long-Term Care Facility</u>	\$ <u>49.22</u>	\$ <u>49.22</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>14,391.08</u>	\$ <u>14,391.08</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 & 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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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 Number Cumberland Rehab & Health Care Center

0048603

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

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

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

N/A

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

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

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

XI. OWNERSHIP COSTS:

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	60	2006	1969	\$ 1,140,000	\$	30	\$ 38,000	\$ 38,000	\$ 57,000	4
5										5
6										6
7	Home Office Allocation			6,572			160	160		7
8										8
Improvement Type**										
9	Land Improvements		2006	10,000		15	666	666	999	9
10	Landscaping		2007	7,307		15	244	244	244	10
11	Patio		2007	1,925		15	64	64	64	11
12	Signage		2007	1,303		10	65	65	65	12
13	Blinds/Window Treatments		2007	17,759		10	888	888	888	13
14	Parking Lot		2007	4,500		15	150	150	150	14
15										15
16										16
17										17
18										18
19	Building Booked				45,600			(45,600)		19
20	Land Improvements Booked				1,134			(1,134)		20
21	Building Improvements Booked				893			(893)		21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31	2007-Home Office Allocation-Building Improvements			440			26	26		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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 1,189,806	\$ 47,627		\$ 40,263	\$ (7,364)	\$ 59,410	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 204,346	\$ 29,192	\$ 20,435	\$ (8,757)	10	\$ 30,652	71
72	Current Year Purchases	8,239	1,007	412	(595)	10	412	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			1,178	1,178			74
75	TOTALS	\$ 212,585	\$ 30,199	\$ 22,025	\$ (8,174)		\$ 31,064	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2007 Ford Econoline Van	2007	\$ 28,328	\$ 2,361	\$ 2,833	\$ 472		\$ 2,833	76
77										77
78										78
79										79
80	TOTALS			\$ 28,328	\$ 2,361	\$ 2,833	\$ 472		\$ 2,833	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)	\$ 1,570,719	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 80,187	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 65,121	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (15,066)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 93,307	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	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

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		<u>Home Office Allocation</u>			<u>24</u>			6
7	TOTAL				\$ <u>24</u>			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ 5,408 Description: See 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			<u>N/A</u>	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2008 \$ _____

13. _____/2009 \$ _____

14. _____/2010 \$ _____

* 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
0048603

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Copier	\$ 3,799
Dishwasher	290
Laundry Equipment	60
Medical Equipment	948
Home Office Allocation	311
	<u>5,408</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L. 10A, C. 3	hrs	\$	538	\$ 8,006	\$	538	\$ 8,006	1
2	Licensed Speech and Language Development Therapist	L. 10A ,C. 3	hrs		99	1,482		99	1,482	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L. 10A, C. 3	hrs		1,480	22,205		1,480	22,205	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L. 39, C. 2	# of prescripts				9,282		9,282	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	2,117	\$ 31,693	\$ 9,282	2,117	\$ 40,975	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

0048603

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (579,830)	\$ (579,830)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	264,024	264,024	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,719	7,719	6
7	Other Prepaid Expenses	8,211	8,211	7
8	Accounts Receivable (owners or related parties)	(100,000)	(100,000)	8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (399,876)	\$ (399,876)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		140,000	13
14	Buildings, at Historical Cost	1,303,732	1,157,012	14
15	Leasehold Improvements, at Historical Cost	12,974	32,794	15
16	Equipment, at Historical Cost	247,001	240,913	16
17	Accumulated Depreciation (book methods)	(104,752)	(93,307)	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: <u>Loan Costs</u>)	21,427	21,427	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,480,382	\$ 1,498,839	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,080,506	\$ 1,098,963	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 139,051	\$ 139,051	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	37,381	37,381	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,334	2,334	31
32	Accrued Real Estate Taxes(Sch.IX-B)	15,000	15,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	11,560	11,560	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 205,326	\$ 205,326	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	26,375	26,375	39
40	Mortgage Payable	1,115,968	1,115,968	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due to Prior Owner</u>	3,194	3,194	43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,145,537	\$ 1,145,537	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,350,863	\$ 1,350,863	46
47	TOTAL EQUITY(page 18, line 24)	\$ (270,357)	\$ (251,900)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,080,506	\$ 1,098,963	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(209,956)	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) R/E as of 1/1/07-Not Required to Prev Rpt	(60,401)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (270,357)	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)	\$ (270,357)	24 *

* This must agree with page 17, line 47.

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

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

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,169,397	1
2	Discounts and Allowances for all Levels	43,628	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,213,025	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	40,879	6
7	Oxygen	764	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 41,643	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	3,458	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	13,910	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	519	20
21	Other Medical Services	2,646	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,533	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	<u>Miscellaneous Revenue-See Sch. 19A</u>	3,283	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,283	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,278,484	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	365,034	31
32	Health Care	609,244	32
33	General Administration	243,735	33
	B. Capital Expense		
34	Ownership	214,063	34
	C. Ancillary Expense		
35	Special Cost Centers	30,435	35
36	Provider Participation Fee	25,929	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,488,440	40
41	Income before Income Taxes (line 30 minus line 40)**	(209,956)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (209,956)	43

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

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

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

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

Cumberland Rehab & Health Care Center
0048603

Period Beginning 01/01/2007

Period End 12/31/2007

Schedule 19A

XVII. INCOME STATEMENT

Line 28a - Other revenue

Insurance Proceeds	1,817
Grain Income	1,236
Office Supplies	<u>230</u>

3,283

Facility Name & ID Number Cumberland Rehab & Health Care Center

0048603

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

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	2,048	2,048	\$ 45,090	\$ 22.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,399	5,529	102,237	18.49	3
4	Licensed Practical Nurses	7,129	7,504	119,388	15.91	4
5	CNAs & Orderlies	20,417	20,821	193,362	9.29	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,022	2,070	18,971	9.16	9
10	Activity Assistants					10
11	Social Service Workers	2,080	2,080	22,829	10.98	11
12	Dietician					12
13	Food Service Supervisor	2,159	2,183	23,015	10.54	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,278	9,492	65,624	6.91	15
16	Dishwashers					16
17	Maintenance Workers	2,104	2,153	28,004	13.01	17
18	Housekeepers	5,620	5,825	45,922	7.88	18
19	Laundry	2,208	2,247	19,646	8.74	19
20	Administrator	2,332	2,368	57,415	24.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	100	136	1,441	10.60	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>Care Plan Coord</u>	2,043	2,075	36,337	17.51	33
34	TOTAL (lines 1 - 33)	64,939	66,531	\$ 779,281 *	\$ 11.71	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 10,700	L. 9, C. 3	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 600	L. 10, C. 3	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 11,300		49

C. CONTRACT NURSES

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

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		
Glenna Birch	Administrator	0	\$ 26,208	Workers' Compensation Insurance	\$ 5,798	IDPH License Fee	\$		
Glenda Fritschle	Administrator	0	15,601	Unemployment Compensation Insurance	17,433	Advertising: Employee Recruitment	195		
Suzanne McKibben	Administrator	0	15,606	FICA Taxes	57,861	Health Care Worker Background Check	(380)		
				Employee Health Insurance	23,464	(Indicate # of checks performed _____)			
				Employee Meals					
				Illinois Municipal Retirement Fund (IMRF)*		LTC Solutions License	1,600		
						Miscellaneous Dues & Licenses	1,244		
						Home Office Allocation	432		
TOTAL (agree to Schedule V, line 17, col. 1)				Employee Retirement	37				
(List each licensed administrator separately.)			\$ 57,415	Employee Relations	370				
B. Administrative - Other									
Description			Amount						
Management Fees-See Page 6, Eliminated on P 3, C 7			\$ 37,000						
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 37,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 104,963		
(Attach a copy of any management service agreement)									
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
E-Health Data Solutions	Computer Services		\$ 2,025				Out-of-State Travel	\$	
Mediacom	Computer Services		1,171						
AB Computers	Computer Services		260	N/A			In-State Travel		
Terry Linder	Cutstom Blueprints		200						
							Seminar Expense		
							Home Office Allocation	306	
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,656					TOTAL	

* Attach copy of IMRF notifications

**See instructions.

Cumberland Rehab & Health Care Center
0048603
Period Beginning 01/01/2007
Period End 12/31/2007

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		3,656

Non-allowable legal expense

Home Office Allocation

Petersen Health Care, Inc

Pearl & Associates	Legal	13
Addy Bush & Assoc	Legal	7
Registered Agent Solutions	Legal	1
Heyl, Royster, Voelker & Allen	Legal	29
Duane Morris	Legal	45
Ginoli & Co.	Accountants	456
RSM McGladrey	Accountants	79
McGladrey & Pullen	Accountants	120
Emdeon Business Services	Computer Services	31
Advanced Answers on Demand	Computer Services	845
Access 2 Go	Computer Services	64
Ivans	Computer Services	56
Kemper Technology	Computer Services	133
Adminastar Federal	Computer Services	16
Logmein	Computer Services	10
E-Health Data Solutions	Computer Services	83
Miscellaneous Vendors	Miscellaneous	6

Petersen Companies, LLC

Miscellaneous Vendors	Legal	32
Ginoli & Co.	Accountants	279
McGladrey & Pullen	Accountants	385

Non-allowable Legal

Total (agree to Schedule V, line 19, column 8)	<u>6,346</u>
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Facility Name & ID Number Cumberland Rehab & Health Care Center# 0048603Report Period Beginning: 01/01/2007Ending: 12/31/2007**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (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? 10 Yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,536 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. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 25,929
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. \$ 3,458
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees