

Facility Name & ID Number Cumberland Rehab & Health Care Center

0048603 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>54</u>	Skilled (SNF)	<u>54</u>	<u>19,764</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>54</u>	TOTALS	<u>54</u>	<u>19,764</u>	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	<u>7,024</u>	<u>4,038</u>	<u>2,324</u>	<u>13,386</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,024</u>	<u>4,038</u>	<u>2,324</u>	<u>13,386</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.73%

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 2,311

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number Cumberland Rehab & Health Care Center # 0048603 Report Period Beginning: 1/1/2008 Ending: 12/31/2008

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	94,027	10,066		104,093		104,093	2,379	106,472		1
2	Food Purchase		76,040		76,040		76,040	(5,591)	70,449		2
3	Housekeeping	86,970	9,879		96,849		96,849	18	96,867		3
4	Laundry	15,058	4,334		19,392		19,392	1	19,393		4
5	Heat and Other Utilities			68,319	68,319		68,319	247	68,566		5
6	Maintenance	9,530	5,457	17,407	32,394		32,394	1,454	33,848		6
7	Other (specify):* <u>Home Off. Ben. All.</u>							585	585		7
8	TOTAL General Services	205,585	105,776	85,726	397,087		397,087	(907)	396,180		8
	B. Health Care and Programs										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	532,612	30,724	1,552	564,888		564,888	4,130	569,018		10
10a	Therapy			202,670	202,670		202,670		202,670		10a
11	Activities	18,059	327	634	19,020		19,020		19,020		11
12	Social Services	12,400			12,400		12,400		12,400		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* <u>Home Off. Ben. All.</u>							721	721		15
16	TOTAL Health Care and Programs	563,071	31,051	218,056	812,178		812,178	4,851	817,029		16
	C. General Administration										
17	Administrative	58,332			58,332		58,332	18,522	76,854		17
18	Directors Fees										18
19	Professional Services			4,900	4,900		4,900	3,446	8,346		19
20	Dues, Fees, Subscriptions & Promotions			6,152	6,152		6,152	868	7,020		20
21	Clerical & General Office Expenses		2,116	6,843	8,959		8,959	25,243	34,202		21
22	Employee Benefits & Payroll Taxes			270,335	270,335		270,335		270,335		22
23	Inservice Training & Education			535	535		535	183	718		23
24	Travel and Seminar							141	141		24
25	Other Admin. Staff Transportation			2,001	2,001		2,001	2,291	4,292		25
26	Insurance-Prop.Liab.Malpractice			3,952	3,952		3,952	173	4,125		26
27	Other (specify):* <u>Home Off. Ben. All.</u>							6,617	6,617		27
28	TOTAL General Administration	58,332	2,116	294,718	355,166		355,166	57,484	412,650		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	826,988	138,943	598,500	1,564,431		1,564,431	61,428	1,625,859		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:

1/1/2008

Ending:

12/31/2008

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			86,255	86,255		86,255	(14,515)	71,740			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			70,125	70,125		70,125	5,616	75,741			32
33	Real Estate Taxes			18,437	18,437		18,437	340	18,777			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,476	4,476		4,476	324	4,800			35
36	Other (specify):*											36
37	TOTAL Ownership			179,293	179,293		179,293	(8,235)	171,058			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		53,756		53,756		53,756		53,756			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,646	29,646		29,646		29,646			42
43	Other (specify):* Non-allowable Cost		409	27,168	27,577		27,577	(27,577)				43
44	TOTAL Special Cost Centers		54,165	56,814	110,979		110,979	(27,577)	83,402			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	826,988	193,108	834,607	1,854,703		1,854,703	25,616	1,880,319			45

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

Cumberland Rehab & Health Care Center

ID# 0048603

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,119)	43	1
2	X-Rays-Part A	(2,163)	43	2
3	Offset Miscellaneous Office Supplies Revenue	(70)	21	3
4	Resident Flowers	(508)	43	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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31				31
32				32
33				33
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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	(4,860)		49

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	1 Dietary	\$	Petersen Health Care, Inc.	100.00%	\$ 2,379	\$ 2,379	1	
2	V	2 Food		Petersen Health Care, Inc.	100.00%	39	39	2	
3	V	3 Housekeeping		Petersen Health Care, Inc.	100.00%	18	18	3	
4	V	4 Laundry		Petersen Health Care, Inc.	100.00%	1	1	4	
5	V	5 Utilities		Petersen Health Care, Inc.	100.00%	247	247	5	
6	V	6 Maintenance		Petersen Health Care, Inc.	100.00%	1,454	1,454	6	
7	V	7 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	585	585	7	
8	V	10 Nursing and Medical Records		Petersen Health Care, Inc.	100.00%	4,130	4,130	8	
9	V	11 Activities		Petersen Health Care, Inc.	100.00%	0		9	
10	V	15 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	721	721	10	
11	V	17 Administrative		Petersen Health Care, Inc.	100.00%	18,522	18,522	11	
12	V	19 Professional Services		Petersen Health Care, Inc.	100.00%	2,090	2,090	12	
13	V							13	
14	Total		\$			\$ 30,186	\$ *	30,186	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%	\$ 645	\$	645	15
16	V	21 Clerical and General Office		Petersen Health Care, Inc.	100.00%	23,244		23,244	16
17	V	23 Inservice Training and Education		Petersen Health Care, Inc.	100.00%	141		141	17
18	V	24 Travel and Seminar		Petersen Health Care, Inc.	100.00%	141		141	18
19	V	25 Other Admin. Staff Transportation		Petersen Health Care, Inc.	100.00%	1,830		1,830	19
20	V	26 Insurance-Prop./Liab/Malpractice		Petersen Health Care, Inc.	100.00%	111		111	20
21	V	27 Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	6,617		6,617	21
22	V	30 Depreciation		Petersen Health Care, Inc.	100.00%	2,532		2,532	22
23	V	32 Interest		Petersen Health Care, Inc.	100.00%	1,781		1,781	23
24	V	33 Real Estate Taxes		Petersen Health Care, Inc.	100.00%	340		340	24
25	V	34 Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0			25
26	V	35 Rent-Equipment and Vehicles		Petersen Health Care, Inc.	100.00%	290		290	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		\$			\$ 37,672	\$ *	37,672	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 Companies, LLC	100.00%	\$ 0	\$	15	
16	V	2 Food		Petersen Companies, LLC	100.00%	0		16	
17	V	3 Housekeeping		Petersen Companies, LLC	100.00%	0		17	
18	V	4 Laundry		Petersen Companies, LLC	100.00%	0		18	
19	V	5 Utilities		Petersen Companies, LLC	100.00%	0		19	
20	V	6 Maintenance		Petersen Companies, LLC	100.00%	0		20	
21	V	7 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		21	
22	V	10 Nursing and Medical Records		Petersen Companies, LLC	100.00%	0		22	
23	V	10A Therapy		Petersen Companies, LLC	100.00%	0		23	
24	V	15 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		24	
25	V	17 Administrative		Petersen Companies, LLC	100.00%	0		25	
26	V	19 Professional Services		Petersen Companies, LLC	100.00%	1,356	1,356	26	
27	V	20 Dues, Fees, Subs & Promotions		Petersen Companies, LLC	100.00%	223	223	27	
28	V	21 Clerical and General Office		Petersen Companies, LLC	100.00%	2,069	2,069	28	
29	V	23 Inservice Training & Education		Petersen Companies, LLC	100.00%	42	42	29	
30	V	24 Travel and Seminar		Petersen Companies, LLC	100.00%	0		30	
31	V	25 Other Admin. Staff Transport.		Petersen Companies, LLC	100.00%	461	461	31	
32	V	26 Insurance-Prop./Liab./Malprac.		Petersen Companies, LLC	100.00%	62	62	32	
33	V	27 Mgmt. Allocation of Benefits		Petersen Companies, LLC	100.00%	0		33	
34	V	30 Depreciation		Petersen Companies, LLC	100.00%	673	673	34	
35	V	32 Interest		Petersen Companies, LLC	100.00%	6,041	6,041	35	
36	V	33 Real Estate Taxes		Petersen Companies, LLC	100.00%	0		36	
37	V	34 Rent-Facility and Grounds		Petersen Companies, LLC	100.00%	0		37	
38	V	35 Rent-Equipment & Vehicles		Petersen Companies, LLC	100.00%	34	34	38	
39	Total		\$			\$ 10,961	\$ *	10,961	39

* 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: 1/1/2008 Ending: 12/31/2008

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	1,810,152	0.56	0.93	Salary	18,522	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	\$ 18,522		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:

1/1/2008Ending: 2/31/2008

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	1,413,604	69	251,260	250,687	13,386	\$ 2,379	1
2	2	Food	Resident Days	1,413,604	69	4,125	0	13,386	39	2
3	3	Housekeeping	Resident Days	1,413,604	69	1,859	0	13,386	18	3
4	4	Laundry	Resident Days	1,413,604	69	110	0	13,386	1	4
5	5	Utilities	Resident Days	1,413,604	69	26,036	0	13,386	247	5
6	6	Maintenance	Resident Days	1,413,604	69	153,551	100,245	13,386	1,454	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	61,774	0	13,386	585	7
8	10	Nursing and Medical Records	Resident Days	1,413,604	69	436,084	432,530	13,386	4,130	8
9	10A	Therapy	Resident Days	1,413,604	69	0	0	13,386	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	76,136	0	13,386	721	10
11	17	Administrative	Resident Days	1,413,604	69	1,955,999	1,956,000	13,386	18,522	11
12	19	Professional Services	Resident Days	1,413,604	69	220,762	0	13,386	2,090	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,413,604	69	68,094	0	13,386	645	13
14	21	Clerical and General Office	Resident Days	1,413,604	69	2,454,596	2,013,896	13,386	23,244	14
15	23	Inservice Training & Education	Resident Days	1,413,604	69	14,912	0	13,386	141	15
16	24	Travel and Seminar	Resident Days	1,413,604	69	14,938	0	13,386	141	16
17	25	Other Admin. Staff Transport.	Resident Days	1,413,604	69	193,264	0	13,386	1,830	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,413,604	69	11,767	0	13,386	111	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,413,604	69	698,810	0	13,386	6,617	19
20	30	Depreciation	Resident Days	1,413,604	69	267,426	0	13,386	2,532	20
21	32	Interest	Resident Days	1,413,604	69	188,107	0	13,386	1,781	21
22	33	Real Estate Taxes	Resident Days	1,413,604	69	35,872	0	13,386	340	22
23	34	Rent-Facility and Grounds	Resident Days	1,413,604	69	0	0	13,386	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,413,604	69	30,580	0	13,386	290	24
25	TOTALS					\$ 7,166,062	\$ 4,753,358		\$ 67,858	25

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

Report Period Beginning:

1/1/2008Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization

Petersen 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

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	227,342	13	\$	13,386	\$	1
2	2	Food	Resident Days	227,342	13		13,386		2
3	3	Housekeeping	Resident Days	227,342	13		13,386		3
4	4	Laundry	Resident Days	227,342	13		13,386		4
5	5	Utilities	Resident Days	227,342	13		13,386		5
6	6	Maintenance	Resident Days	227,342	13		13,386		6
7	7	Mgmt. Allocation of Benefits	Resident Days	227,342	13		13,386		7
8	10	Nursing and Medical Records	Resident Days	227,342	13		13,386		8
9	10A	Therapy	Resident Days	227,342	13		13,386		9
10	15	Mgmt. Allocation of Benefits	Resident Days	227,342	13		13,386		10
11	17	Administrative	Resident Days	227,342	13		13,386		11
12	19	Professional Services	Resident Days	227,342	13	23,031	13,386	1,356	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	227,342	13	3,794	13,386	223	13
14	21	Clerical and General Office	Resident Days	227,342	13	35,146	13,386	2,069	14
15	23	Inservice Training & Education	Resident Days	227,342	13	706	13,386	42	15
16	24	Travel and Seminar	Resident Days	227,342	13		13,386		16
17	25	Other Admin. Staff Transport.	Resident Days	227,342	13	7,835	13,386	461	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	227,342	13	1,053	13,386	62	18
19	27	Mgmt. Allocation of Benefits	Resident Days	227,342	13		13,386		19
20	30	Depreciation	Resident Days	227,342	13	11,428	13,386	673	20
21	32	Interest	Resident Days	227,342	13	102,603	13,386	6,041	21
22	33	Real Estate Taxes	Resident Days	227,342	13		13,386		22
23	34	Rent-Facility and Grounds	Resident Days	227,342	13		13,386		23
24	35	Rent-Equipment & Vehicles	Resident Days	227,342	13	585	13,386	34	24
25	TOTALS					\$ 186,181	\$	\$ 10,961	25

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

Report Period Beginning:

1/1/2008

Ending:

12/31/2008**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**					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	Bank of America		X	Mortgage	Varies	10/31/07	\$ 1,120,000	\$ 1,099,840	10/31/12	Varies	\$ 61,565	1					
2	Associated Bank		X	Vehicle	\$579.98	07/23/07	28,328	21,460	07/23/12	0.0828	2,044	2					
3							Interest Income Offset				(1,101)	3					
4							Home Office Allocation-PHC				1,781	4					
5							Home Office Allocation-PC				6,041	5					
	Working Capital																
6							Farm Income offset				(1,105)	6					
7												7					
8												8					
9	TOTAL Facility Related				\$579.98		\$ 1,148,328	\$ 1,121,300			\$ 69,225	9					
	B. Non-Facility Related*																
10												10					
11							Amortization Expense				6,516	11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 6,516	14					
15	TOTALS (line 9+line14)						\$ 1,148,328	\$ 1,121,300			\$ 75,741	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.)

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 2007 report.		\$	15,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2007	\$	16,437	2
3. Under or (over) accrual (line 2 minus line 1).		\$	1,437	3
4. Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	17,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. Home Office Allocation			340	
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	18,777	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	8
	2004	9
	2005	10
	2006	14,391
	2007	16,437

Accrual based on prior year tax bill.

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

2007 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 2007 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 2007.

(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>16,181.46</u>	\$ <u>16,181.46</u>
2. <u>13-02-203-015</u>	<u>Long-Term Care Facility</u>	\$ <u>83.70</u>	\$ <u>83.70</u>
3. <u>13-02-203-016</u>	<u>Long-Term Care Facility</u>	\$ <u>9.80</u>	\$ <u>9.80</u>
4. <u>13-02-203-020</u>	<u>Long-Term Care Facility</u>	\$ <u>162.00</u>	\$ <u>162.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>16,436.96</u>	\$ <u>16,436.96</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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? (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

Facility Name & ID Number Cumberland Rehab & Health Care Center

0048603

Report Period Beginning:

1/1/2008

Ending:

12/31/2008

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	\$ 95,000	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Land Improvements		2006	10,000		15	667	667	1,666	9
10	Landscaping		2007	7,307		15	487	487	731	10
11	Patio		2007	1,925		15	128	128	192	11
12	Signage		2007	1,303		10	130	130	195	12
13	Blinds/Window Treatments		2007	17,759		10	1,776	1,776	2,664	13
14	Parking Lot		2007	4,500		15	300	300	450	14
15	Dry valve replacement		2008	3,653		15	122	122	122	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	Building Booked				45,600			(45,600)		28
29	Building Improvement Booked				3,537			(3,537)		29
30										30
31										31
32	2008-Home Office Allocation-Land Improvements			465			30	30		32
33	2008-Home Office Allocation-Building Improvements			6,950			167	167		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)	\$ 1,193,862	\$ 49,137		\$ 41,807	\$ (7,330)	\$ 101,020	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	\$ 212,585	\$ 31,452	\$ 21,259	\$ (10,193)	10	\$ 52,323	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74	Home Office Allocation			3,008	3,008			74
75	TOTALS	\$ 212,585	\$ 31,452	\$ 24,267	\$ (7,185)		\$ 52,323	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	\$ 5,666	\$ 5,666	\$	5	\$ 8,499	76
77										77
78										78
79										79
80	TOTALS			\$ 28,328	\$ 5,666	\$ 5,666	\$		\$ 8,499	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)	\$ 1,574,775	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 86,255	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,740	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (14,515)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 161,842	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions							4
5								5
6								6
7	TOTAL				\$ _____			7

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

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

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

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

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

YES NO

16. Rental Amount for movable equipment: \$ 4,800 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			<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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

* 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 1/1/2008

Period End 12/31/2008

Schedule 14A

XII. Rental Costs

B. Equipment

16. Description of rental amount for movable equipment

Medical Equipment	\$	453
Dishwasher		134
Copier		3,889
Home Office Allocation		324
		<u>4,800</u>
		<u><u>4,800</u></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>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. <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		3	4
		1	2		
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	1,755	\$ 26,320	\$	1,755	\$ 26,320	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		702	10,524		702	10,524	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		11,055	165,826		11,055	165,826	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				53,756		53,756	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): _____									12
13	Other (specify): _____									13
14	TOTAL			\$	13,512	\$ 202,670	\$ 53,756	13,512	\$ 256,426	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: 1/1/2008

Ending: 12/31/2008

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2008

(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	\$ (533,776)	\$ (533,776)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>N/A</u>)	527,352	527,352	3
4	Supply Inventory (priced at _____)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,353	13,353	6
7	Other Prepaid Expenses	5,711	5,711	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): _____			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 12,640	\$ 12,640	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	1,146,950	14
15	Leasehold Improvements, at Historical Cost	16,627	46,912	15
16	Equipment, at Historical Cost	247,001	240,913	16
17	Accumulated Depreciation (book methods)	(191,006)	(161,842)	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>)	21,505	21,505	22
23	Other(specify): _____			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,397,859	\$ 1,434,438	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,410,499	\$ 1,447,078	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 279,886	\$ 279,886	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	44,440	44,440	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,932	2,932	31
32	Accrued Real Estate Taxes(Sch.IX-B)	17,000	17,000	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>	15,631	15,631	36
37	_____			37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 359,889	\$ 359,889	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	21,460	21,460	39
40	Mortgage Payable	1,099,840	1,099,840	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	_____			43
44	_____			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,121,300	\$ 1,121,300	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,481,189	\$ 1,481,189	46
47	TOTAL EQUITY(page 18, line 24)	\$ (70,690)	\$ (34,111)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,410,499	\$ 1,447,078	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (270,357)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (270,357)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	199,667	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 199,667	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)	\$ (70,690)	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	\$ 1,496,057	1
2	Discounts and Allowances for all Levels	194,986	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,691,043	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	260,733	6
7	Oxygen	1,136	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 261,869	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	5,630	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	85,872	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,126	20
21	Other Medical Services	3,554	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 99,182	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,101	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,101	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Miscellaneous Revenue</u>	1,175	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,175	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,054,370	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	397,087	31
32	Health Care	812,178	32
33	General Administration	355,166	33
	B. Capital Expense		
34	Ownership	179,293	34
	C. Ancillary Expense		
35	Special Cost Centers	81,333	35
36	Provider Participation Fee	29,646	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,854,703	40
41	Income before Income Taxes (line 30 minus line 40)**	199,667	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 199,667	43

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

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

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

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

Facility Name & ID Number Cumberland Rehab & Health Care Center

0048603

Report Period Beginning: 1/1/2008

Ending: 12/31/2008

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	1,860	1,860	\$ 40,378	\$ 21.71	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,022	7,214	137,500	19.06	3
4	Licensed Practical Nurses	5,765	6,013	99,763	16.59	4
5	CNAs & Orderlies	22,301	22,889	216,048	9.44	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,817	1,908	18,059	9.46	9
10	Activity Assistants					10
11	Social Service Workers	889	1,033	12,400	12.00	11
12	Dietician					12
13	Food Service Supervisor	1,850	2,015	21,766	10.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,269	9,421	72,261	7.67	15
16	Dishwashers					16
17	Maintenance Workers	637	637	9,530	14.96	17
18	Housekeepers	8,199	8,562	86,970	10.16	18
19	Laundry	1,503	1,713	15,058	8.79	19
20	Administrator	3,025	3,025	58,332	19.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					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>	2,027	2,175	38,923	17.90	33
34	TOTAL (lines 1 - 33)	66,164	68,465	\$ 826,988 *	\$ 12.08	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	9(3)	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 600	10(3)	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 13,800		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

Cumberland Rehab & Health Care Center

0048603

Period Beginning 1/1/2008

Period End 12/31/2008

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		4,900

Home Office Allocation

Heyl, Royster, Voelker & Allen	Legal	76
GoffWilson, P.A.	Legal	254
Ginoli & Company	Accountants	1,973
RSM McGladrey	Accountants	6
Miscellaneous Vendors	Computer Services	28
Emdeon Business Services	Computer Services	41
Advanced Answers on Demand	Computer Services	480
Access 2 Go	Computer Services	142
Ivans	Computer Services	74
Kemper Technology	Computer Services	260
VisionShare	Computer Services	28
Logmein	Computer Services	20
Comm Net Communiations	Computer Services	7
Charter Communications	Computer Services	6
Advanced System Designs	Computer Services	9
Consolidated Communications	Computer Services	6
Miscellaneous Vendors	Miscellaneous	36

Total (agree to Schedule V, line 19, column 8)	<u>8,346</u>
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Cumberland Rehab & Health Care Center

0048603

Period Beginning 1/1/2008

Period End 12/31/2008

XIX. SUPPORT SCHEDULES

Schedule 21B

A. Administrative Salaries

Name	Function	Ownership %	Amount
Glenda Fritschle	Administrator	0	27,301
Sharon Hamilton	Administrator	0	11,628
Katherine Hanner	Administrator	0	19,403
	Total		<u>58,332</u>

Facility Name & ID Number Cumberland Rehab & Health Care Center# 0048603Report Period Beginning: 1/1/2008Ending: 12/31/2008**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. 570 -IHCA
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? No
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? N/A
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,695 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? N/A
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 29,646
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. \$ 5,630
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ No
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Adequate records have been maintained.
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ No
- (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