

Facility Name & ID Number RIVER BLUFF NURSING HOME

0005611 Report Period Beginning: 10/1/05 Ending: 9/30/06

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 _____

	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	304	Skilled (SNF)	304	111,264	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	304	TOTALS	304	111,264	7

B. Census-For the entire report period.

	1 Level of Care	3 Patient Days by Level of Care and Primary Source of Payment				5
		2 Medicaid Recipient		4 Other	Total	
		Private Pay				
8	SNF	5,163	0	0	5,163	8
9	SNF/PED					9
10	ICF	72,504	5,867	4,001	82,372	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	77,667	5,867	4,001	87,535	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.67%

D. How many bed-hold days during this year were paid by the Department? 0 (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)
N/A

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

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

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

I. On what date did you start providing long term care at this location?
Date started 6/1/1971

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 76 and days of care provided 1,886

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: _____ Fiscal Year: _____

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

STATE OF ILLINOIS

Facility Name & ID Number **RIVER BLUFF NURSING HOME** # **0005611** Report Period Beginning: **10/1/05** Ending: **9/30/06**

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	826,095	28,421	100,264	954,780		954,780	157,667	1,112,447		1
2	Food Purchase		603,058		603,058		603,058	(24,516)	578,542		2
3	Housekeeping	254,420	147,749	2,131	404,300		404,300	48,051	452,351		3
4	Laundry	317,949	37,516	335	355,800		355,800	61,565	417,365		4
5	Heat and Other Utilities			562,542	562,542		562,542		562,542		5
6	Maintenance	277,369	9,560	229,596	516,525		516,525	52,556	569,081		6
7	Other (specify):*										7
8	TOTAL General Services	1,675,833	826,304	894,868	3,397,005		3,397,005	295,323	3,692,328		8
B. Health Care and Programs											
9	Medical Director			16,200	16,200		16,200		16,200		9
10	Nursing and Medical Records	5,409,211	282,903	804,156	6,496,270		6,496,270	1,078,340	7,574,610		10
10a	Therapy										10a
11	Activities	180,479	1,053	9,500	191,032		191,032	34,537	225,569		11
12	Social Services	130,858		3,967	134,825		134,825	25,527	160,352		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	5,720,548	283,956	833,823	6,838,327		6,838,327	1,138,404	7,976,731		16
C. General Administration											
17	Administrative	134,160	12,983	484,552	631,695	(166,440)	465,255	85,590	550,845		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			2,754	2,754		2,754		2,754		20
21	Clerical & General Office Expenses	311,118		1,429,361	1,740,479		1,740,479		1,740,479		21
22	Employee Benefits & Payroll Taxes										22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration	445,278	12,983	1,916,667	2,374,928	(166,440)	2,208,488	85,590	2,294,078		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	7,841,659	1,123,243	3,645,358	12,610,260	(166,440)	12,443,820	1,519,317	13,963,137		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

RIVER BLUFF NURSING HOME

#0005611

Report Period Beginning:

10/1/05

Ending:

9/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			384,751	384,751		384,751		384,751			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			22,632	22,632		22,632		22,632			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			407,383	407,383		407,383		407,383			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					166,440	166,440		166,440			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					166,440	166,440		166,440			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	7,841,659	1,123,243	4,052,741	13,017,643		13,017,643	1,519,317	14,536,960			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(24,516)	V27		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (24,516)		\$	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*	6,957	V107	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,536,876	See Attach	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 1,543,833		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 1,519,317		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

RIVER BLUFF NURSING HOME

ID# 0005611

Report Period Beginning: 10/1/05

Ending: 9/30/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			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	0	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

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	Medicare	\$	WINNEBAGO COUNTY	100.00%	\$ 109,163	\$ 109,163	1
2	V	IMRF		WINNEBAGO COUNTY	100.00%	598,430	598,430	2
3	V	FICA		WINNEBAGO COUNTY	100.00%	465,692	465,692	3
4	V	Workers Compensation		WINNEBAGO COUNTY	100.00%	328,303	328,303	4
5	V	Unemployment		WINNEBAGO COUNTY	100.00%	35,288	35,288	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$ 1,536,876	\$ * 1,536,876	14

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

Facility Name & ID Number RIVER BLUFF NURSING HOME # 0005611 Report Period Beginning: 10/1/05 Ending: 9/30/06

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

Facility Name & ID Number RIVER BLUFF NURSING HOME # 0005611 Report Period Beginning: 10/1/05 Ending: 9/30/06

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 County of Winnebago
 Street Address 404 Elm St, Room 520
 City / State / Zip Code Rockford, IL 61101
 Phone Number (815) 319-4050
 Fax Number (815) 319-4051

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

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17-3 COUNTY AUDITOR	OPERATING EXP	91,137,172	11	\$ 426,289	\$ 356,710	10,961,173	\$ 51,270	1
2	17-3 COUNTY BOARD	OPERATING EXP	91,137,172	11	570,498	482,506	10,961,173	68,614	2
3	17-3 COUNTY TREASURER	OPERATING EXP	91,137,172	11	506,619	337,325	10,961,173	60,932	3
4	17-3 HUMAN RESOURCES	OPERATING EXP	91,137,172	11	328,419	271,564	10,961,173	39,499	4
5	17-3 PURCHASING	OPERATING EXP	91,137,172	11	140,052	109,597	10,961,173	16,844	5
6	17-3 STATES ATTORNEY - CIVIL	OPERATING EXP	91,137,172	11	366,774	366,774	10,961,173	44,112	6
7	17-3 STATES ATTORNEY - LOGLI	OPERATING EXP	91,137,172	11	144,817	144,817	10,961,173	17,417	7
8	17-3 COUNTY FINANCE	OPERATING EXP	91,137,172	11	72,296	61,998	10,961,173	8,695	8
9	17-3 Auditing and accounting	OPERATING EXP	91,137,172	11	284,638	0	10,961,173	34,234	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 2,840,402	\$ 2,131,291		\$ 341,617	25

Facility Name & ID Number RIVER BLUFF NURSING HOME # 0005611 Report Period Beginning: 10/1/05 Ending: 9/30/06

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 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	2003 C Nursing Home Bonds			ROOF REPAIR	ANNUAL	9/1/2003	\$ 900,000	\$ 460,000	6/3/2008	0.0280	\$ 22,632	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 900,000	\$ 460,000			\$ 22,632	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 900,000	\$ 460,000			\$ 22,632	15

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

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

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

Facility Name & ID Number **RIVER BLUFF NURSING HOME**

0005611 Report Period Beginning: **10/1/05** Ending: **9/30/06**

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																											
1. Real Estate Tax accrual used on 2005 report.		\$ N/A	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.)		\$	2																								
3. Under or (over) accrual (line 2 minus line 1).		\$	3																								
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																								
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																								
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																								
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																								
Real Estate Tax History:																											
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>8</td></tr> <tr><td>2002</td><td>9</td></tr> <tr><td>2003</td><td>10</td></tr> <tr><td>2004</td><td>11</td></tr> <tr><td>2005</td><td>12</td></tr> </table>	2001	8	2002	9	2003	10	2004	11	2005	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2005 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2001	8																										
2002	9																										
2003	10																										
2004	11																										
2005	12																										
FOR BHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2005 \$	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: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 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 2006 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,

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME RIVER BLUFF NURSING HOME COUNTY WINNEBAGO

FACILITY IDPH LICENSE NUMBER 0005611

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(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. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocation:

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 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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: 145,000 B. General Construction Type: Exterior BRICK Frame Non-Combustible 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 ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

NA

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	BUILDING SITE	3,277,019	1971	\$ 5,830	1
2					2
3	TOTALS	3,277,019		\$ 5,830	3

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

Facility Name & ID Number **RIVER BLUFF NURSING HOME** STATE OF ILLINOIS # **0005611** Report Period Beginning: **10/1/05** Ending: **9/30/06** Page 12

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 OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	304		1971	1971	\$ 4,393,166	\$ 109,829	40	\$ 109,829		\$ 3,909,539	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9			1973		13,347	334	40	334		11,178	9
10			1974		3,221	81	40	81		2,617	10
11			1975		16,713	418	40	418		13,162	11
12			1976		3,971	99	40	99		3,027	12
13			1977		18,218	455	40	455		13,436	13
14			1978		13,203	330	40	330		9,408	14
15			1979		21,430	536	40	536		15,362	15
16			1980		4,512	113	40	113		2,989	16
17			1981		20,593	0	20	0		20,593	17
18			1982		975	0	20	0		975	18
19			1983		17,590	0	40	0		17,590	19
20			1986		269,023	6,726	20 #	6,726		269,023	20
21			1987		134,110	6,706	20	6,706		130,758	21
22			1988		7,854	393	20 #	393		7,265	22
23			1989		4,560	228	20	228		3,990	23
24			1990		4,833	242	20	242		3,987	24
25			1990		106,822	0	20	0		0	25
26			1991		24,310	1,215	20	1,215		18,840	26
27			1992		27,382	1,369	20	1,369		19,852	27
28		Building Improvements 2003	1993		320	16	20	16		216	28
29		New Blacktop - \$4,566	1994		33,937	1,697	20	1,697		21,211	29
30		Building structure improvements - \$273,709	1995		71,170	3,559	20	3,559		40,923	30
31		Guard rails and gates - \$4,960	1996		25,411	1,270	20	1,270		12,712	31
32		Architectural services - \$2,625	1997		117,237	5,862	20	5,862		55,687	32
33		Electrical upgrades - \$14,614	1998		14,879	744	20	744		6,323	33
34			1999		42,536	2,127	20	2,127		15,951	34
35			2000		94,842	4,742	20	4,742		30,824	35
36											36

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

See Page 12A, Line 70 for total

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

Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available.

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	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Land Improvements 2004	2001	\$ 44,762	\$ 2,238	20	\$ 2,238		\$ 12,310	37
38		2001	68,374	0	0	0		0	38
39	Blacktop - \$79,676.25	2002	379,998	19,000	20	19,000		85,500	39
40	Building Improvements	2003	300,474	14,795	20	14,795		51,898	40
41	Remodel Project - \$132,805	2004	1,617,574	76,895	20	76,895		192,237	41
42	Replace Roof \$1,405,093	2005	77,680	3,884	40	3,884		5,826	42
43		2005	18,975	949	20	949	0	1,423	43
44		2006	272,911	6,823	20	6,823		6,823	44
45									45
46									46
47				4,138		4,138		1,262	47
48	2005 Additions								48
49									49
50	Major Building Repairs - \$77,679.50								50
51	Upgrade doors to safety Standards - \$18,975								51
52									52
53									53
54	2006 Additions								54
55	Land Improvements 2006								55
56	Sidewalk replacement - \$6,296								56
57	Pavement repairs - \$18,400								57
58									58
59	Building Improvements								59
60	Asbestos removal and fire alarm project \$174,722								60
61	Boiler replacement and generator work - \$73,493								61
62									62
63									63
64	Machinery and Equipment								64
65	Computer Hardware and Server - \$34,200								65
66	GL software - \$16,199								66
67	Range and tables - \$36,727								67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 8,286,913	\$ 277,813		\$ 277,813	\$ 0	\$ 5,014,717	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	\$ 1,262,004	\$ 92,576	\$ 92,576	\$ (0)		\$ 1,003,659	71
72	Current Year Purchases	89,601	8,301	8,301			8,301	72
73	Fully Depreciated Assets							73
74	Adjusted to General Ledger	4,383						74
75	TOTALS	\$ 1,355,988	\$ 100,877	\$ 100,877	\$ (0)		\$ 1,011,960	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	Residnet Outings	Superior Bus	1999	\$ 34,167	\$	\$	\$	4	\$ 34,167	76
77	County Collectors	Ford Taurus Wagon	2000	16,079				4	16,079	77
78	Plowing & maintenance	Truck	2003	24,245	6,061	6,061			21,214	78
79										79
80	TOTALS			\$ 74,491	\$ 6,061	\$ 6,061	\$		\$ 71,460	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,723,222 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 384,751 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 384,751 83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0) 84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,098,137 85

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

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

G. Construction-in-Progress

	Description	Cost	
92	Fire Alarm	\$ 90,623	92
93			93
94			94
95	TOTALS	\$ 90,623	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: _____

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

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. _____ /2007 \$ _____

13. _____ /2008 \$ _____

14. _____ /2009 \$ _____

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: \$ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. 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			Total
		1 Drop-outs	2 Completed	3 Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

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	

- (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		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							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			\$		\$	\$		\$	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.

STATE OF ILLINOIS

Facility Name & ID Number **RIVER BLUFF NURSING HOME** # **0005611** Report Period Beginning: **10/1/05** Ending: **9/30/06**
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of **9/30/06** (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	\$ 2,438	\$	1
2	Cash-Patient Deposits	50,759		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,086,493)	2,329,114		3
4	Supply Inventory (priced at cost)	85,578		4
5	Short-Term Investments	1,606,084		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	10,943		8
9	Other(specify): Common Cash	1,107,311		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,192,227	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,830		13
14	Buildings, at Historical Cost	4,487,780		14
15	Leasehold Improvements, at Historical Cost	3,799,131		15
16	Equipment, at Historical Cost	1,430,440		16
17	Accumulated Depreciation (book methods)	(6,098,137)		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: Bond issue costs)	12,869		22
23	Other(specify): Construction in progress	90,623		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,728,536	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 8,920,763	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 435,910	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	155,327		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,107		33
34	Deferred Compensation	91,067		34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	Trust Deposits	50,759		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 736,170	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	460,000		41
42	Deferred Compensation	234,174		42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 694,174	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,430,344	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 7,490,419	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 8,920,763	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,612,875	1
2	Restatements (describe):		2
3	Represent adjustments to Accounts Receivable prior	122,258	3
4	to Annual Audit being issued		4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 9,735,133	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,244,714)	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)	\$ (2,244,714)	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)	\$ 7,490,419	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number RIVER BLUFF NURSING HOME

0005611

Report Period Beginning: 10/1/05

Ending:

Page 19
9/30/06

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	\$ 10,676,600	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,676,600	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	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	24,516	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 24,516	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	71,813	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 71,813	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,772,929	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	3,397,005	31
32	Health Care	6,838,327	32
33	General Administration	2,208,488	33
B. Capital Expense			
34	Ownership	407,383	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	166,440	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,017,643	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,244,714)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,244,714)	43

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

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

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

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

Facility Name & ID Number RIVER BLUFF NURSING HOME

0005611

Report Period Beginning: 10/1/05

Ending: 9/30/06

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	1,864	2,080	\$ 72,450	\$ 34.83	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,181	41,458	1,216,881	29.35	3
4	Licensed Practical Nurses	50,449	56,831	1,324,497	23.31	4
5	CNAs & Orderlies	196,711	220,786	2,631,590	11.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,792	2,080	25,384	12.20	9
10	Activity Assistants	13,658	15,510	155,095	10.00	10
11	Social Service Workers	10,157	11,666	130,858	11.22	11
12	Dietician					12
13	Food Service Supervisor	7,619	8,855	127,510	14.40	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,638	12,554	134,941	10.75	15
16	Dishwashers	51,908	57,048	560,529	9.83	16
17	Maintenance Workers	17,921	20,780	277,369	13.35	17
18	Housekeepers	23,964	27,104	256,341	9.46	18
19	Laundry	26,799	30,358	317,598	10.46	19
20	Administrator	1,800	2,080	73,424	35.30	20
21	Assistant Administrator	1,952	2,080	60,735	29.20	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	22,269	24,777	310,311	12.52	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)	15,162	17,132	166,146	9.70	33
34	TOTAL (lines 1 - 33)	490,844	553,179	\$ 7,841,659 *	\$ 14.18	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	\$ 27,778		35
36	Medical Director	16,200		36
37	Medical Records Consultant	5,552		37
38	Nurse Consultant			38
39	Pharmacist Consultant	3,000		39
40	Physical Therapy Consultant	40,144		40
41	Occupational Therapy Consultant	40,882		41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant	4,638		43
44	Activity Consultant	1,404		44
45	Social Service Consultant	1,143		45
46	Other(specify) Pastoral Care	1,426		46
47	RUGS III	70,951		47
48				48
49	TOTAL (lines 35 - 48)	\$ 213,118		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,025	\$ 40,006	50
51	Licensed Practical Nurses	3,689	128,589	51
52	Certified Nurse Assistants/Aides	10,348	203,206	52
53	TOTAL (lines 50 - 52)	15,063	\$ 371,801	53

XIX. SUPPORT SCHEDULES				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
A. Administrative Salaries				Description			Description	
Name	Function	Ownership %	Amount	Amount			Amount	
Phyllis Schwebke	Administrator		\$ 73,424	Workers' Compensation Insurance		\$ See Pg 6	IDPH License Fee	\$
Pam Gentner	Asst. Admin		60,735	Unemployment Compensation Insurance		See Pg 6	Advertising: Employee Recruitment	
				FICA Taxes		See Pg 6	Health Care Worker Background Check (Indicate # of checks performed _____)	
				Employee Health Insurance		1,422,446		
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		See Pg 6	Dues and membership	2,754
				Life Insurance		6,915		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$				Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,429,361	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 2,754
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
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)				TOTAL		\$	TOTAL	\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number RIVER BLUFF NURSING HOME# 0005611

Report Period Beginning:

10/1/05

Ending:

9/30/06**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. County Nursing Home Association #2560
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? NA
- (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? _____
- (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. \$ _____ Line _____
- (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. NA
- (9) Are you presently operating under a sublease agreement? YES X NO _____
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 166,400
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 benefit: on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ _____
- (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. \$ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NO
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. \$ NA
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: Milliken Benning Kleckler and Kobishika The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. AUDIT IN PROGRESS
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? NO
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.