



Facility Name & ID Number RIVER BLUFF NURSING HOME

# 0005611 Report Period Beginning: 10/1/06 Ending: 9/30/07

**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	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5	
		2 Medicaid Recipient	3 Private Pay	4 Other		
8	SNF	5,285	0	2,442	7,727	8
9	SNF/PED					9
10	ICF	74,372	6,381	1,389	82,142	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	79,657	6,381	3,831	89,869	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.77%

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? N/A

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 2,442

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

Page 3

Facility Name &amp; ID Number RIVER BLUFF NURSING HOME # 0005611 Report Period Beginning: 10/1/06 Ending: 9/30/07

## 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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	918,889	34,049	103,499	1,056,437		1,056,437	193,985	1,250,422		1
2	Food Purchase		687,834		687,834		687,834	(31,226)	656,608		2
3	Housekeeping	259,924	146,265	2,867	409,056		409,056	54,872	463,928		3
4	Laundry	347,475	50,281	150	397,906		397,906	73,355	471,261		4
5	Heat and Other Utilities			474,333	474,333		474,333		474,333		5
6	Maintenance	358,847	13,465	269,634	641,946		641,946	75,755	717,701		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	1,885,135	931,894	850,483	3,667,512		3,667,512	366,741	4,034,253		8
<b>B. Health Care and Programs</b>											
9	Medical Director			16,200	16,200		16,200		16,200		9
10	Nursing and Medical Records	6,391,038	257,176	646,073	7,294,287		7,294,287	1,414,603	8,708,890		10
10a	Therapy										10a
11	Activities	174,252	1,640	9,717	185,609		185,609	36,786	222,395		11
12	Social Services	144,310		3,322	147,632		147,632	30,465	178,097		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	6,709,600	258,816	675,312	7,643,728		7,643,728	1,481,854	9,125,582		16
<b>C. General Administration</b>											
17	Administrative	323,226	17,661	487,865	828,752	(166,440)	662,312	68,236	730,548		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			2,700	2,700		2,700		2,700		20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes			1,569,908	1,569,908		1,569,908		1,569,908		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	<b>TOTAL General Administration</b>	323,226	17,661	2,060,473	2,401,360	(166,440)	2,234,920	68,236	2,303,156		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	8,917,961	1,208,371	3,586,268	13,712,600	(166,440)	13,546,160	1,916,831	15,462,991		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 &amp; ID Number

RIVER BLUFF NURSING HOME

#0005611

Report Period Beginning:

10/1/06

Ending:

9/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			369,948	369,948		369,948	369,948				30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,716	16,716		16,716	16,716				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			386,664	386,664		386,664	386,664				37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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	<b>TOTAL Special Cost Centers</b>					166,440	166,440	166,440				44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	8,917,961	1,208,371	3,972,932	14,099,264		14,099,264	1,916,831	16,016,095			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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(31,226)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (31,226)		\$	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*	8,068	V107	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,939,988	See Attach	34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,948,056		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 1,916,830		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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

RIVER BLUFF NURSING HOME

ID# 0005611

Report Period Beginning: 10/1/06

Ending: 9/30/07

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	<b>Total</b>	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	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	MEDICARE	\$	Winnebago County	100.00%	\$ 125,145	\$	125,145	1
2	V	IMRF		Winnebago County	100.00%	673,943		673,943	2
3	V	FICA		Winnebago County	100.00%	532,715		532,715	3
4	V	WORKERS COMPENSATION		Winnebago County	100.00%	550,849		550,849	4
5	V	UNEMPLOYMENT		Winnebago County	100.00%	57,336		57,336	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		\$			\$ 1,939,988	\$ *	1,939,988	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: 10/1/06 Ending: 9/30/07

## 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: 10/1/06 Ending: 9/30/07

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, ILLINOIS 61101  
 Phone Number ( 815 319-4055  
 Fax Number ( 815 319-4051

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	17-3	COUNTY AUDITOR	91,137,172	11	\$ 290,185	\$ 243,126	10,961,173	\$ 34,901	1
2	17-3	COUNTY BOARD	91,137,172	11	599,749	514,045	10,961,173	72,133	2
3	17-3	COUNTY TREASURER	91,137,172	11	485,954	309,841	10,961,173	58,446	3
4	17-3	HUMAN RESOURCES	91,137,172	11	362,940	304,655	10,961,173	43,651	4
5	17-3	PURCHASING	91,137,172	11	154,307	118,617	10,961,173	18,559	5
6	17-3	STATES ATTY - CIVIL	91,137,172	11	394,413	394,413	10,961,173	47,437	6
7	17-3	STATES ATTY - LOGLI	91,137,172	11	158,100	158,100	10,961,173	19,015	7
8	17-3	COUNTY FINANCE	91,137,172	11	304,788	262,492	10,961,173	36,657	8
9	17-3	Audit and Accounting	91,137,172	11	135,000	0	10,961,173	16,237	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				\$ 2,885,436	\$ 2,305,289		\$ 347,036	25

Facility Name & ID Number RIVER BLUFF NURSING HOME # 0005611 Report Period Beginning: 10/1/06 Ending: 9/30/07

**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				
	<b>A. Directly Facility Related</b>											
	<b>Long-Term</b>											
1	2003 C Nursing Home Bonds			Roof Repair	Annual	9/1/03	\$ 900,000	\$ 235,000	6/3/08	0.0280	\$ 12,430	1
2												2
3												3
4												4
5												5
	<b>Working Capital</b>											
6												6
7												7
8												8
9	<b>TOTAL Facility Related</b>						\$ 900,000	\$ 235,000			\$ 12,430	9
	<b>B. Non-Facility Related*</b>											
10												10
11												11
12												12
13												13
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14
15	<b>TOTALS (line 9+line14)</b>						\$ 900,000	\$ 235,000			\$ 12,430	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: **10/1/06** Ending: **9/30/07**

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

**B. Real Estate Taxes**

<p><b>Important</b>, 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 2006 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 2007 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$	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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	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>2002</td><td>8</td></tr> <tr><td>2003</td><td>9</td></tr> <tr><td>2004</td><td>10</td></tr> <tr><td>2005</td><td>11</td></tr> <tr><td>2006</td><td>12</td></tr> </table>	2002	8	2003	9	2004	10	2005	11	2006	12	<table border="1"> <tr><td colspan="2"><b>FOR BHF USE ONLY</b></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2006 \$</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>		<b>FOR BHF USE ONLY</b>		13	FROM R. E. TAX STATEMENT FOR 2006 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2002	8																										
2003	9																										
2004	10																										
2005	11																										
2006	12																										
<b>FOR BHF USE ONLY</b>																											
13	FROM R. E. TAX STATEMENT FOR 2006 \$	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: 2006 REAL ESTATE TAX COST DOCUMENTATION

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

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

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2006 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 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007

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

**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)

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:**

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

Facility Name & ID Number RIVER BLUFF NURSING HOME

# 0005611

Report Period Beginning:

10/1/06

Ending:

9/30/07

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	304	1971	1971	\$ 4,393,166	\$ 109,829	40	\$ 109,829	\$	\$ 4,019,368	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9			1973	13,347	334	40	334		11,512	9
10			1974	3,221	81	40	81		2,698	10
11			1975	16,713	418	40	418		13,580	11
12			1976	3,971	99	40	99		3,126	12
13			1977	18,218	455	40	455		13,891	13
14			1978	13,203	330	40	330		9,738	14
15			1979	21,430	536	40	536		15,898	15
16			1980	4,512	113	40	113		3,102	16
17			1981	20,593		20			20,593	17
18	Building Improvements 2003		1982	975		20			975	18
19	New Blacktop - \$4,566		1983	17,590		20			17,590	19
20	Building structure improvements - \$273,709		1986	269,023		20			269,023	20
21	Guard rails and gates - \$4,960		1987	134,110	3,352	20	3,352		134,110	21
22	Architectural services - \$2,625		1988	7,854	393	20	393		7,658	22
23	Electrical upgrades - \$14,614		1989	4,560	228	20	228		4,218	23
24			1990	4,833	242	20	242		3,987	24
25			1990	106,822		20				25
26	Land Improvements 2004		1991	24,310	1,215	20	1,215		20,056	26
27			1992	27,382	1,369	20	1,369		21,221	27
28	Blacktop - \$79,676.25		1993	320	16	20	16		232	28
29	Building Improvements		1994	33,937	1,697	20	1,697		22,908	29
30	Remodel Project - \$132,805		1995	71,170	3,559	20	3,559		44,482	30
31	Replace Roof \$1,405,093		1996	25,411	1,270	20	1,270		13,983	31
32			1997	117,237	5,862	20	5,862		61,549	32
33			1998	14,879	744	20	744		7,067	33
34			1999	42,536	2,127	20	2,127		18,078	34
35			2000	94,842	4,742	20	4,742		35,566	35
36										36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number RIVER BLUFF NURSING HOME

# 0005611

Report Period Beginning:

10/1/06

Ending:

9/30/07

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	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	2005 Additions	\$ 44,762	\$ 2,238	20	\$ 2,238		\$ 14,548		37
38		68,374							38
39	Major Building Repairs - \$77,679.50	379,998	19,000	20	19,000		104,499		39
40	Upgrade doors to safety Standards - \$18,975	295,908	14,795	20	14,795		66,693		40
41		4,566							41
42		1,617,574	76,895	40	76,895		269,132		42
43	2006 Additions	77,680	3,884	20	3,884		9,710		43
44	Land Improvements 2006	18,975	949	20	949		2,372		44
45	Sidewalk replacement - \$6,296	272,911	13,646	20	13,646		20,468		45
46	Pavement repairs - \$18,400	136,310	3,408	20	3,408	0	3,408		46
47									47
48	Building Improvements								48
49	Asbestos removal and fire alarm project \$174,722								49
50	Boiler replacement and generator work - \$73,493								50
51									51
52									52
53	Machinery and Equipment								53
54	Computer Hardware and Server - \$34,200								54
55	GL software - \$16,199								55
56	Range and tables - \$36,727								56
57									57
58	2007								58
59	Fire Alarm System \$136,310								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)	\$ 8,423,223	\$ 273,826		\$ 273,826	\$ 0	\$ 5,287,040		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	\$ 1,355,950	\$ 93,575	\$ 93,575	\$		\$ 1,104,157	71
72	Current Year Purchases	20,439	2,547	2,547			2,547	72
73	Fully Depreciated Assets							73
74	Adjusted to GL							74
75	TOTALS	\$ 1,376,389	\$ 96,122	\$ 96,122	\$		\$ 1,106,704	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	\$	\$			\$ 34,167	76
77	County Collectors	Ford Taurus Wagon	2000	16,079					16,079	77
78	Plowing & maintenance	Truck	2003	24,245					24,245	78
79										79
80	TOTALS			\$ 74,491	\$	\$	\$		\$ 74,491	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)	\$ 9,879,933	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 369,948	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 369,948	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)	\$ 6,468,235	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		\$	92
93			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: \_\_\_\_\_

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

If NO, see instructions.  YES  NO

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

10. Effective dates of current rental agreement:  
Beginning \_\_\_\_\_  
Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
12.	_____/2008	\$ _____
13.	_____/2009	\$ _____
14.	_____/2010	\$ _____

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	<b>TOTAL</b>		\$ _____	\$ _____	21

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

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

**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. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

- (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	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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	<b>TOTAL</b>			\$		\$		\$		\$		\$		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

Page 17

Facility Name &amp; ID Number RIVER BLUFF NURSING HOME

# 0005611

Report Period Beginning: 10/1/06

Ending:

9/30/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 9/30/07

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 64	\$	1
2	Cash-Patient Deposits	50,324		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 307,032 )	3,363,113		3
4	Supply Inventory (priced at )	85,470		4
5	Short-Term Investments	776,188		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	9,826		8
9	Other(specify):	5,499,271		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 9,784,256	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,830		13
14	Buildings, at Historical Cost	8,423,222		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,450,880		16
17	Accumulated Depreciation (book methods)	(6,468,232)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	7,721		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 3,419,421	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 13,203,677	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,271,891	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	163,148		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,645		33
34	Deferred Compensation	88,202		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37	<b>Bonds payable - Current</b>	235,000		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,759,886	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	251,035		42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 251,035	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,010,921	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 11,192,756	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 13,203,677	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ 10,152,421	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ 10,152,421	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	7,186,391	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	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 7,186,391	17
<b>B. Transfers (Itemize):</b>			
18			18
19	Adjustment for IDPA Medicaid Trasfers	(6,146,056)	19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$ (6,146,056)	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 11,192,756	24 *

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

STATE OF ILLINOIS

Facility Name & ID Number RIVER BLUFF NURSING HOME

# 0005611

Report Period Beginning: 10/1/06

Ending:

Page 19  
9/30/07

**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 18,144,520	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 18,144,520	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	49,510	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 49,510	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Real Estate Tax Transfer</b>	3,091,625	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 3,091,625	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 21,285,655	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	3,667,512	31
32	Health Care	7,643,728	32
33	General Administration	2,234,920	33
<b>B. Capital Expense</b>			
34	Ownership	386,664	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	166,440	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,099,264	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	7,186,391	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 7,186,391	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 &amp; ID Number RIVER BLUFF NURSING HOME

# 0005611

Report Period Beginning: 10/1/06

Ending: 9/30/07

## 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	1,772	2,080	\$ 76,840	\$ 36.94	1
2	Assistant Director of Nursing					2
3	Registered Nurses	38,168	42,776	1,298,376	30.35	3
4	Licensed Practical Nurses	53,842	60,714	1,432,498	23.59	4
5	CNAs & Orderlies	224,410	252,208	3,220,956	12.77	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,824	2,080	28,749	13.82	9
10	Activity Assistants	13,226	15,690	165,427	10.54	10
11	Social Service Workers	10,707	12,285	144,603	11.77	11
12	Dietician					12
13	Food Service Supervisor	6,702	7,667	116,851	15.24	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,303	12,189	136,572	11.20	15
16	Dishwashers	59,805	65,791	654,054	9.94	16
17	Maintenance Workers	24,393	27,187	381,403	14.03	17
18	Housekeepers	22,828	25,682	259,817	10.12	18
19	Laundry	27,942	31,601	347,448	10.99	19
20	Administrator	1,770	2,080	77,257	37.14	20
21	Assistant Administrator	1,904	2,080	62,557	30.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,044	28,687	350,554	12.22	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)	14,005	15,715	163,999	10.44	33
34	TOTAL (lines 1 - 33)	538,645	606,512	\$ 8,917,961 *	\$ 14.70	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	\$ 33,496	35
36	Medical Director	16,200	36
37	Medical Records Consultant	5,280	37
38	Nurse Consultant		38
39	Pharmacist Consultant	3,000	39
40	Physical Therapy Consultant	53,954	40
41	Occupational Therapy Consultant	34,279	41
42	Respiratory Therapy Consultant	1,266	42
43	Speech Therapy Consultant	11,340	43
44	Activity Consultant	1,410	44
45	Social Service Consultant	1,138	45
46	Other(specify) Pastoral Care	1,426	46
47	RUGS III	94,207	47
48			48
49	TOTAL (lines 35 - 48)	\$ 256,995	49

## C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$ 944	50	
51	Licensed Practical Nurses	1,901	51	
52	Certified Nurse Assistants/Aides	660	52	
53	TOTAL (lines 50 - 52)	3,505	\$ 117,877	53

Facility Name & ID Number RIVER BLUFF NURSING HOME

# 0005611

Report Period Beginning: 10/1/06

Ending: 9/30/07

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
PHYLLIS SCHWEBKE	ADMINISTRATOR		\$ 77,257	Workers' Compensation Insurance	\$ SEE PG 6	IDPH License Fee	\$	
PAM GENTNER	ASST. ADMIN		62,557	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	1,562,746			
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*	SEE PG 6	<b>DUES AND MEMBERSHIP</b>	<b>2,700</b>	
				<b>LIFE INSURANCE</b>	<b>7,162</b>			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 139,814					
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
			\$			\$	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.



**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 ASSOC #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 YR
- (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.