



Facility Name & ID Number River Bluff Nursing Home

# 0005611 Report Period Beginning: 10/01/16 Ending: 09/30/17

**III. STATISTICAL DATA**

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	304	Skilled (SNF)	304	110,960	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	110,960	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	789		2,019	2,808	8
9	SNF/PED					9
10	ICF	61,198	7,665	8,007	76,870	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,987	7,665	10,026	79,678	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.81%

D. How many bed reserve days during this year were paid by the Department? None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
None

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

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

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

I. On what date did you start providing long term care at this location?  
Date started 06/01/1971

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 152 and days of care provided 2,019

Medicare Intermediary National Government Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 9/30/2017 Fiscal Year: 9/30/2017

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/16 Ending: 09/30/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	872,748	71,302	37,765	981,815		981,815		981,815		1
2	Food Purchase		774,730		774,730		774,730	(25,568)	749,162		2
3	Housekeeping	317,442	124,859		442,301		442,301		442,301		3
4	Laundry	15,242	499,932	59	515,233		515,233		515,233		4
5	Heat and Other Utilities			362,330	362,330		362,330		362,330		5
6	Maintenance	461,038	143,136	193,791	797,965		797,965	(125,575)	672,390		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	<b>1,666,470</b>	<b>1,613,959</b>	<b>593,945</b>	<b>3,874,374</b>		<b>3,874,374</b>	<b>(151,143)</b>	<b>3,723,231</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			17,400	17,400		17,400		17,400		9
10	Nursing and Medical Records	5,426,280	456,343	1,149,116	7,031,739		7,031,739		7,031,739		10
10a	Therapy	209,348			209,348		209,348		209,348		10a
11	Activities	243,239	3,076	5,135	251,450		251,450		251,450		11
12	Social Services	165,007	1,625	1,440	168,072		168,072		168,072		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>6,043,874</b>	<b>461,044</b>	<b>1,173,091</b>	<b>7,678,009</b>		<b>7,678,009</b>		<b>7,678,009</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	176,623		400,463	577,086		577,086	(32,952)	544,134		17
18	Directors Fees										18
19	Professional Services			113,275	113,275		113,275	(13,194)	100,081		19
20	Dues, Fees, Subscriptions & Promotions			29,937	29,937		29,937		29,937		20
21	Clerical & General Office Expenses	376,642	24,899	665,623	1,067,164		1,067,164	(246,015)	821,149		21
22	Employee Benefits & Payroll Taxes			1,507,956	1,507,956		1,507,956	1,852,349	3,360,305		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,268	6,268		6,268		6,268		24
25	Other Admin. Staff Transportation			2,884	2,884		2,884		2,884		25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	<b>553,265</b>	<b>24,899</b>	<b>2,726,406</b>	<b>3,304,570</b>		<b>3,304,570</b>	<b>1,560,188</b>	<b>4,864,758</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>8,263,609</b>	<b>2,099,902</b>	<b>4,493,442</b>	<b>14,856,953</b>		<b>14,856,953</b>	<b>1,409,045</b>	<b>16,265,998</b>		<b>29</b>

\*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:

10/01/16

Ending:

09/30/17

## 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			469,440	469,440		469,440	(3,847)	465,593			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,101	31,101		31,101	(45)	31,056			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			59,562	59,562		59,562		59,562			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			560,103	560,103		560,103	(3,892)	556,211			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		66,342	580,675	647,017		647,017		647,017			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			639,062	639,062		639,062		639,062			42
43	Other (specify):*			365	365		365	(365)				43
44	<b>TOTAL Special Cost Centers</b>		66,342	1,220,102	1,286,444		1,286,444	(365)	1,286,079			44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	8,263,609	2,166,244	6,273,647	16,703,500		16,703,500	1,404,788	18,108,288			45

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

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

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**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	(22,818)	02		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	(3,847)	30		9
10	Interest and Other Investment Income	(45)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(245,703)	21		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	(129,002)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (401,415)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,806,203		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 1,806,203		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 1,404,788		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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River Bluff Nursing Home

ID# 0005611

Report Period Beginning: 10/01/16

Ending: 09/30/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Uniform Fees	\$ (262)	21	1
2	R&M Interdepartment Charges	(44,368)	06	2
3	Marketing	(365)	43	3
4	Capitalized R&M	(81,207)	06	4
5	Vending Income	(2,750)	02	5
6	Jury Duty Income	(50)	21	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>	(129,002)		49

River Bluff Nursing Home

Report Period Beginning:                     10/01/16                      
 Ending:   09/30/17                    

ID#                     0005611                    

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98	<b>Total</b>		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number River Bluff Nursing Home# 0005611

Report Period Beginning:

10/01/16

Ending:

09/30/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(25,568)											(25,568)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(125,575)											(125,575)	6
7	Other (specify):*													7
8	<b>TOTAL General Services</b>	<b>(151,143)</b>											<b>(151,143)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(32,952)									(32,952)	17
18	Directors Fees													18
19	Professional Services			(13,194)									(13,194)	19
20	Fees, Subscriptions & Promotions													20
21	Clerical & General Office Expenses	(246,015)											(246,015)	21
22	Employee Benefits & Payroll Taxes		1,852,349										1,852,349	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>	<b>(246,015)</b>	<b>1,852,349</b>	<b>(46,146)</b>									<b>1,560,188</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(397,158)</b>	<b>1,852,349</b>	<b>(46,146)</b>									<b>1,409,045</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/16 Ending: 09/30/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(3,847)											(3,847)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(45)											(45)	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>	<b>(3,892)</b>											<b>(3,892)</b>	<b>37</b>
	<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													42
43	Other (specify):*	(365)											(365)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(365)</b>											<b>(365)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(401,415)</b>	<b>1,852,349</b>	<b>(46,146)</b>									<b>1,404,788</b>	<b>45</b>

**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Winnebago County	100%	None		None		

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	22 Emp Benefits IMRF	\$	Winnebago County	100.00%	\$ 731,663	\$ 731,663	1
2	V	22 Medicare Payroll Taxes		Winnebago County	100.00%	118,029	118,029	2
3	V	22 Payroll Taxes		Winnebago County	100.00%	503,708	503,708	3
4	V	22 Workers Comp		Winnebago County	100.00%	491,618	491,618	4
5	V	22 Unemployment Taxes		Winnebago County	100.00%	7,331	7,331	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		\$			\$ 1,852,349	\$ * 1,852,349	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: 10/01/16

Ending: 09/30/17

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 <u>County Auditor</u>	\$	<u>Winnebago County</u>	100.00%	\$ 30,367	\$	30,367	15
16	V	17 <u>County Board</u>		<u>Winnebago County</u>	100.00%	95,161		95,161	16
17	V	17 <u>County Treasurer</u>		<u>Winnebago County</u>	100.00%	58,608		58,608	17
18	V	17 <u>Human Resources</u>		<u>Winnebago County</u>	100.00%	38,631		38,631	18
19	V	17 <u>Purchasing</u>		<u>Winnebago County</u>	100.00%	20,070		20,070	19
20	V	17 <u>States Attorney - Civil</u>		<u>Winnebago County</u>	100.00%	75,763		75,763	20
21	V	17 <u>States Attorney - Bruscato</u>		<u>Winnebago County</u>	100.00%	19,949		19,949	21
22	V	17 <u>County Finance</u>		<u>Winnebago County</u>	100.00%	28,962		28,962	22
23	V	19 <u>Audit &amp; Accounting</u>		<u>Winnebago County</u>	100.00%	16,806		16,806	23
24	V	17 <u>Administrative</u>	400,463	<u>Winnebago County</u>				(400,463)	24
25	V								25
26	V								26
27	V	19 <u>Data Processing</u>	30,000					(30,000)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$ 430,463			\$ 384,317	\$ *	(46,146)	39

\* 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: 10/01/16

Ending: 09/30/17

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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:

10/01/16

Ending:

09/30/17

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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: 10/01/16

Ending: 09/30/17

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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: 10/01/16

Ending: 09/30/17

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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: 10/01/16

Ending: 09/30/17

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

\* 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: 10/01/16 Ending: 09/30/17

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	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1								\$		1
2	<b>Note: No Member of The County Board Provided Direct Services To The Nursing Home. In Addition, No Board Member Has Ownership In An Entity That</b>									2
3	<b>Conducted Business Transactions With The Nursing Home During The Reporting Period</b>									3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							<b>TOTAL</b>	\$		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:

10/01/16

Ending: 09/30/17

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 Street Room 520

City / State / Zip Code

Rockford, IL 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	22	Emp Benefits IMRF	Direct Cost	11	\$ 731,663	\$	91,137,172	\$ 731,663	1
2	22	Medicare Payroll Taxes	Direct Cost	11	118,029		91,137,172	118,029	2
3	22	Payroll Taxes	Direct Cost	11	503,708		91,137,172	503,708	3
4	22	Workers Comp	Direct Cost	11	491,618		91,137,172	491,618	4
5	22	Unemployment Taxes	Direct Cost	11	7,331		91,137,172	7,331	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	TOTALS				\$ 1,852,349	\$		\$ 1,852,349	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending: 09/30/17

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 Street Room 520

City / State / Zip Code

Rockford, IL 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	County Auditor	Operating Expense	91,137,172	11	\$ 252,489	\$ 224,633	10,961,173	\$ 30,367	1
2	17	County Board	Operating Expense	91,137,172	11	791,217	718,915	10,961,173	95,161	2
3	17	County Treasurer	Operating Expense	91,137,172	11	487,298	288,152	10,961,173	58,608	3
4	17	Human Resources	Operating Expense	91,137,172	11	321,197	265,339	10,961,173	38,631	4
5	17	Purchasing	Operating Expense	91,137,172	11	166,872	142,040	10,961,173	20,070	5
6	17	States Attorney - Civil	Operating Expense	91,137,172	11	629,932	531,801	10,961,173	75,763	6
7	17	States Attorney - Bruscato	Operating Expense	91,137,172	11	165,870	165,870	10,961,173	19,949	7
8	17	County Finance	Operating Expense	91,137,172	11	240,806	183,551	10,961,173	28,962	8
9	19	Audit and Accounting	Operating Expense	91,137,172	11	139,735		10,961,173	16,806	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					\$ 3,195,416	\$ 2,520,301		\$ 384,317	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( \_\_\_\_\_

Fax Number ( \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( \_\_\_\_\_

Fax Number ( \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( \_\_\_\_\_

Fax Number ( \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611 Report Period Beginning: 10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number (\_\_\_\_\_) \_\_\_\_\_  
 Fax Number (\_\_\_\_\_) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611 Report Period Beginning: 10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611 Report Period Beginning: 10/01/16

Ending: 09/30/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	TOTALS				\$	\$		\$	25

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending: 09/30/17

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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	<b>TOTALS</b>				\$	\$		\$	25

Facility Name & ID Number

River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending:

09/30/17

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

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

1	Name of Lender	2		3	4	5	6		7	8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required					Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO											Original	Balance			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	County Bond		X	Series 2012A Bonds			\$	\$			\$	31,101						
2																		
3																		
4																		
5																		
<b>Working Capital</b>																		
6																		
7																		
8																		
9	<b>TOTAL Facility Related</b>						\$	\$			\$	31,101						
<b>B. Non-Facility Related*</b>																		
10	Interest Income											(45)						
11																		
12																		
13																		
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	(45)						
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$	31,056						

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

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

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

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2016 report.		\$	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 2017 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:	2012	8
	2013	9
	2014	10
	2015	11
	2016	12

Not Applicable to the Facility

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.**

# 2016 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 Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2016.

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

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES        NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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



Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending:

09/30/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 145,000 B. General Construction Type: Exterior Brick Frame Non-Combustible Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

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

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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:

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Row 1: Facility, 3,277,019, 1971, \$ 5,830, 1. Row 2: (blank), (blank), (blank), (blank), 2. Row 3: TOTALS, 3,277,019, (blank), \$ 5,830, 3.

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	304	1971	1971	\$ 4,453,960	\$	40	\$	\$	\$ 4,453,960	4
5										5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1973	16,186		20			16,186	9
10	Various		1974	3,221		20			3,221	10
11	Various		1975	16,713		20			16,713	11
12	Various		1976	5,790		20			5,790	12
13	Various		1977	18,218		20			18,218	13
14	Various		1978	15,081		20			15,081	14
15	Various		1979	22,567		20			22,567	15
16	Various		1980	4,512		20			4,512	16
17	Various		1981	1,500		20			1,500	17
18	Various		1984	3,882		20			3,882	18
19	Various		1987	9,006		20			9,006	19
20	Various		1988	7,854		20			7,854	20
21	Various		1989	4,560		20			4,560	21
22	Various		1990	4,833		20			4,833	22
23	Various		1991	24,310		20			24,310	23
24	Various		1992	27,382		20			27,382	24
25	Various		1993	320		20			320	25
26	Various		1994	34,377		20			34,377	26
27	Various		1995	71,170		20			71,170	27
28	Various		1996	27,811		20			27,811	28
29	Various		1997	117,237		20	2,930	2,930	117,237	29
30	Various		1998	19,029		20	744	744	18,657	30
31	Various		1999	48,763		20	2,127	2,127	45,574	31
32	Various		2000	88,615		20	4,742	4,742	82,986	32
33	Various		2001	113,136		20	5,657	5,657	50,603	33
34	Various		2002	379,998		20	19,000	19,000	294,499	34
35	Various		2003	300,474		20	15,024	15,024	215,559	35
36	Various		2004	1,617,574		20	76,895	76,895	1,117,758	36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2005	\$ 81,119	\$	20	\$ 4,833	\$ 4,833	\$ 60,410	37
38 Various	2006	272,911		20	13,646	13,646	156,924	38
39 Various	2007	136,310		20	6,816	6,816	71,565	39
40 Various	2008	56,319		20	2,816	2,816	24,775	40
41 Various	2009	46,742		20	2,337	2,337	16,230	41
42 Various	2010	665,059		20	33,253	33,253	265,728	42
43 Various	2011	77,034		20	3,851	3,851	29,872	43
44 Various	2012	197,175		20	9,858	9,858	58,980	44
45 Various	2013	147,442		20	7,372	7,372	36,860	45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67 Related Building Company (Pages 12F & 12G)								67
68 Related Party Allocations (Pages 12H & 12I)								68
69 Financial Statement Depreciation			469,440			(469,440)		69
70 TOTAL (lines 4 thru 69)		\$ 9,138,190	\$ 469,440		\$ 211,900	\$ (257,540)	\$ 7,437,468	70

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

Facility Name &amp; ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending:

09/30/17

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 9,138,190	\$ 469,440		\$ 211,900	\$ (257,540)	\$ 7,437,468	1
2	Sprinkler System	2014	3,025,124		20	151,256	151,256	605,025	2
3	Cooling Coil Replacement	2014	13,990		20	700	700	2,798	3
4	Heating Valve Replacement	2014	13,850		20	693	693	2,770	4
5	Heating Coil Replacement	2014	16,400		20	820	820	3,280	5
6	Oxygen Storage Pipe	2014	13,260		20	663	663	2,652	6
7	Air System Compressor	2014	24,680		20	1,234	1,234	4,936	7
8	New Carpet Tile For The Facility Entrance Way	2014	5,050		20	253	253	1,010	8
9	Repaired/Replaced 15 Damper Assemblies	2014	4,165		20	208	208	833	9
10	Air Handler Unit #3, D Wing- Repairs	2014	14,273		20	714	714	2,855	10
11	New Chiller	2014	4,308		20	215	215	862	11
12	Gravel For Landscaping	2014	13,125		20	656	656	2,625	12
13	Repair Cooling System- Air Handler Not Functioning	2014	24,680		20	1,234	1,234	4,936	13
14	Fire Damper Repairs	2014	14,965		20	748	748	2,993	14
15	New Water Heater	2014	8,308		20	415	415	1,662	15
16	Replaced Heating Coil In Air Handler #2	2014	16,400		20	820	820	3,280	16
17	Removed And Repaired Cooling Coil	2014	11,270		20	564	564	2,254	17
18	Replaced Oxygen Storage Piping	2014	13,260		20	663	663	2,652	18
19	Supply & Install Interior Logo, Illuminated Single Sided Sign	2015	14,280		20	714	714	2,142	19
20	Replaced Compressor	2015	9,875		20	494	494	1,481	20
21	Installed,Piped, And Wired Dish Sink Disposal	2015	7,907		20	395	395	1,186	21
22	Install New Bullhorns/Tenons/Ballast On 2-North Parking Lot Lig	2015	2,855		20	143	143	286	22
23	Design/Fabricate Registers For Dining/Patient Rooms. Install New	2015	5,285		20	264	264	528	23
24	Ups System Pathway Lights/Neighborhood Em Lights	2016	11,200		20	560	560	1,120	24
25	Generator Repair	2016	153,800		20	7,690	7,690	15,380	25
26	Overhaul Trane Centrifugal Chiller & Bearings	2016	51,235		20	2,562	2,562	5,124	26
27	Provide & Install New Heating Coil In Maintenance Area	2016	4,238		20	212	212	424	27
28	Circulating Taco Pump Bldg. A	2016	7,182		20	359	359	718	28
29	Repipe Under Sink Lines, Install Mixing Valves/New Faucet	2016	3,854		20	193	193	385	29
30	Bonnet/Valve/Dial Repair	2016	4,537		20	227	227	454	30
31	Check/Install New Garbage Disposal	2016	3,381		20	169	169	338	31
32	New Chiller Motor	2016	9,385		20	469	469	939	32
33	Replace,Program,Startup, And Commission Cooling Tower Frequ	2016	4,741		20	237	237	474	33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,669,053	\$ 469,440		\$ 388,443	\$ (80,997)	\$ 8,115,868	34

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

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending:

09/30/17

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12B, Carried Forward</b>		\$ 12,669,053	\$ 469,440		\$ 388,443	\$ (80,997)	\$ 8,115,868	1
2	Installation Of Tank	2016	6,724		20	336	336	672	2
3	Electrical Repairs	2016	6,040		20	302	302	604	3
4	Magnaflux, Pressure Test & Resurface Cylinder Heads	2016	6,095		20	305	305	610	4
5	Change Hot Water Cir Pump In C-Wing	2016	2,903		20	145	145	145	5
6	Swap Out Gas And Diesel Pump	2017	2,500		20	125	125	125	6
7	Replace 7 Fire Damper Actuators	2017	4,525		20	226	226	226	7
8	Boiler Repair - Replace Gas Valve Body And Actuator	2017	4,980		20	249	249	249	8
9	Plumbing Work - Install Pump In E-Wing Pump #2	2017	2,936		20	147	147	147	9
10	Change Hot Water Cir Pump In D-Wing	2017	2,936		20	147	147	147	10
11	Excavation And Blacktop - Asphalt Paving	2017	4,672		20	234	234	234	11
12	Replace Dishroom Door	2017	6,609		20	330	330	330	12
13	B-2/B-4 Shower Rooms - Patch/Caulk Wall & Floor Tile, Install C	2017	4,374		20	219	219	219	13
14	Shower Rooms C-2,C-4,D-2,D-4 - Remove Framing, Plywood, Tile	2017	6,196		20	310	310	310	14
15	Install Additional Door In Basement	2017	3,309		20	165	165	165	15
16	Installation Of 3 Fixed Dome/360 Degree Cameras On Patio	2017	10,982		20	549	549	549	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 12,744,832	\$ 469,440		\$ 392,232	\$ (77,208)	\$ 8,120,601	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,744,832	\$ 469,440		\$ 392,232	\$ (77,208)	\$ 8,120,601	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	TOTAL (lines 1 thru 33)	\$ 12,744,832	\$ 469,440		\$ 392,232	\$ (77,208)	\$ 8,120,601	34

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 12,744,832	\$ 469,440		\$ 392,232	\$ (77,208)	\$ 8,120,601	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	TOTAL (lines 1 thru 33)	\$ 12,744,832	\$ 469,440		\$ 392,232	\$ (77,208)	\$ 8,120,601	34

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

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending:

09/30/17

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	<b>Building Company</b>		\$	\$		\$	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending:

09/30/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

**XI. OWNERSHIP COSTS (continued)**

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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	<b>TOTAL (lines 1 thru 33)</b>		\$	\$		\$	\$	\$	34

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

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning:

10/01/16

Ending:

09/30/17

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34	TOTAL (lines 1 thru 33)	\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 524,502	\$	\$ 46,438	\$ 46,438	10	\$ 259,756	71
72	Current Year Purchases	8,211		402	402	10	402	72
73	Fully Depreciated Assets	1,393,289				10	1,393,289	73
74								74
75	TOTALS	\$ 1,926,003	\$	\$ 46,840	\$ 46,840		\$ 1,653,446	75

D. Vehicle Costs. (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Superior Bus	1990	\$ 34,167	\$	\$	\$	5	\$ 34,167	76
77		Ford Taurus Wagon	2000	16,079				5	16,079	77
78		Truck	2003	24,245				5	24,245	78
79		See Attached		160,608		26,522	26,522	5	121,853	79
80	TOTALS			\$ 235,099	\$	\$ 26,522	\$ 26,522		\$ 196,344	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)	\$ 14,911,764	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 469,440	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 465,594	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,847)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,970,391	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.

Facility Name & ID Number River Bluff Nursing Home

# 0005611

Report Period Beginning: 10/01/16

Ending: 09/30/17

**XII. RENTAL COSTS**

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

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.

YES  NO

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending	Annual Rent
--------------------	-------------

12. _____	/2018	\$	_____
13. _____	/2019	\$	_____
14. _____	/2020	\$	_____

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 59,563 Description: See Attached Schedule

(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.

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/16 Ending: 09/30/17

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs				\$ 155,671				\$ 155,671	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				75,353				75,353	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				343,341				343,341	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	Other (specify):											12
13	Other (specify):						6,310	66,342			72,652	13
14	TOTAL						\$ 580,675	\$ 66,342			\$ 647,017	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.

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	\$ 4,062	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	6,034,228		3
4	Supply Inventory (priced at )	107,380		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>	1,899,664		9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 8,045,334	\$	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	4,487,780		14
15	Leasehold Improvements, at Historical Cost	7,745,856		15
16	Equipment, at Historical Cost	2,166,358		16
17	Accumulated Depreciation (book methods)	(9,631,510)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	63,780		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	3,708,836		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 8,546,930	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 16,592,264	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,134,237	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	440,260		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	7,418		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	8,101,643		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 9,683,558	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	461,774		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 461,774	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 10,145,332	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 6,446,932	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 16,592,264	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>5,641,645</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Equity Adjustment</b>	<b>1,271,893</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>6,913,538</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(466,606)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(466,606)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>6,446,932</b>	<b>24</b> *

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

Facility Name & ID Number River Bluff Nursing Home# 0005611Report Period Beginning: 10/01/16

Ending:

09/30/17**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**

I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 17,786,005	1
2	Discounts and Allowances for all Levels	(3,462,192)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 14,323,813	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	37	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	22,818	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>	\$ 22,855	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	45	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 45	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See Supplemental Schedule</b>	1,890,181	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 1,890,181	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 16,236,894	30

II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	3,874,374	31
32	Health Care	7,678,009	32
33	General Administration	3,304,570	33
<b>B. Capital Expense</b>			
34	Ownership	560,103	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	647,382	35
36	Provider Participation Fee	639,062	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 16,703,500	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(466,606)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (466,606)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 10,442,548	44
45	Private Pay - Net Inpatient Revenue	1,264,417	45
46	Medicare - Net Inpatient Revenue	948,646	46
47	Other-(specify) <u>Hospice/Ancillary</u>	1,668,202	47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 14,323,813	49

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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:

10/01/16

Ending:

09/30/17

**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	1,781	2,095	\$ 109,029	\$ 52.04	1
2	Assistant Director of Nursing	1,820	2,076	97,789	47.10	2
3	Registered Nurses	37,779	46,342	1,527,416	32.96	3
4	Licensed Practical Nurses	46,601	52,762	1,406,120	26.65	4
5	CNAs & Orderlies	147,264	166,932	2,160,020	12.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,330	11,807	209,348	17.73	8
9	Activity Director	2,268	2,579	57,310	22.22	9
10	Activity Assistants	15,865	18,412	185,929	10.10	10
11	Social Service Workers	9,457	10,498	165,007	15.72	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,120	57,859	27.29	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,618	15,317	217,293	14.19	15
16	Dishwashers	42,469	46,880	597,596	12.75	16
17	Maintenance Workers	20,009	23,225	461,038	19.85	17
18	Housekeepers	24,619	27,724	317,442	11.45	18
19	Laundry	398	471	15,242	32.36	19
20	Administrator	1,748	2,080	100,386	48.26	20
21	Assistant Administrator	1,797	2,080	76,237	36.65	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	18,920	21,326	376,642	17.66	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	7,502	8,456	125,906	14.89	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	406,085	463,182	\$ 8,263,609 *	\$ 17.84	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	888	\$ 37,765	01-03	35
36	Medical Director	Monthly	17,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	1,509	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	1,987	11-03	44
45	Social Service Consultant	Monthly	1,440	12-03	45
46	Other(specify) <u>Chaplain</u>	Monthly	3,148	11-03	46
47					47
48					48
49	TOTAL (lines 35 - 48)	888	\$ 63,249		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	2,864	\$ 119,351	10-03	50
51	Licensed Practical Nurses	7,150	254,769	10-03	51
52	Certified Nurse Assistants/Aides	41,010	773,487	10-03	52
53	TOTAL (lines 50 - 52)	51,024	\$ 1,147,607		53

Facility Name & ID Number **River Bluff Nursing Home**

# **0005611**

Report Period Beginning: **10/01/16**

Ending: **09/30/17**

**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	
Pamela Gentner	Administrator	0	\$ 100,386	Workers' Compensation Insurance	\$ 491,618	IDPH License Fee	\$	
Monica Plymale	Asst. Admin	0	76,237	Unemployment Compensation Insurance	7,331	Advertising: Employee Recruitment	11,593	
				FICA Taxes	621,737	Health Care Worker Background Check (Indicate # of checks performed <u>242</u> )	7,721	
				Employee Health Insurance	1,502,771	Patient Background Checks		
				Employee Meals		Dues & Subscriptions	588	
				Illinois Municipal Retirement Fund (IMRF)*	731,663	Licenses & Permits	5,189	
				Employee Assistance	5,184	Books, Periodicals, & Manuals	4,846	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 176,623					
B. Administrative - Other								
Description			Amount					
Winnebago County			\$ 400,463			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)			\$ 400,463	TOTAL (agree to Schedule V, line 22, col.8)	\$ 3,360,304	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 29,937	
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
Marcum LLP	Accounting		\$ 11,077				Out-of-State Travel	\$
Mark D. Olson, CPA Ltd.	Accounting		6,420					
Michigan Peer Review Org.	Quality Improvement		1,305					
Duane Morris	Legal		17,321				In-State Travel	
Wescom Solutions	Data Processing		41,053					
Winnebago County	Data Processing		30,000					
Surequest Systems	Food Svc Mngmt Software		4,458				Seminar Expense	6,269
Swits/TeleInterpreters	Translation Services		321					
AJ Gallagher Services	Risk Management		1,320					
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 113,275	TOTAL			Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 6,269

\* 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? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 118,475 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 639,062  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 22,818
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 14  
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? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. **Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes  
Attach invoices and a summary of services for all architect and appraisal fees