

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0005611

Facility Name: River Bluff Nursing Home

Address: 4401 North Main St Rockford 61103
Number City Zip Code

County: Winnebago

Telephone Number: (815) 877-8061 Fax # (815) 877-1069

HFS ID Number:

Date of Initial License for Current Owners: 1971

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☐ PROPRIETARY
☒ GOVERNMENTAL
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other
☒ State
☒ County
☐ Other

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda Telephone Number: (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/15 to 09/30/16 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) * _____ (Date) _____
* Subject to attached Accountant Consulting Report
(Print Name and Title) _____
(Firm Name & Address) Marcum, LLP
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number River Bluff Nursing Home

0005611 Report Period Beginning: 10/01/15 Ending: 09/30/16

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>304</u>	Skilled (SNF)	<u>304</u>	<u>111,264</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>304</u>	TOTALS	<u>304</u>	<u>111,264</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,184</u>		<u>2,132</u>	<u>3,316</u>	8
9	SNF/PED					9
10	ICF	<u>66,142</u>	<u>7,510</u>	<u>5,749</u>	<u>79,401</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>67,326</u>	<u>7,510</u>	<u>7,881</u>	<u>82,717</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.34%

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

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

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

None

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☐ NO ☒

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 2,132

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: 9/30/2016 Fiscal Year: 9/30/2016

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/15 Ending: 09/30/16
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	992,060	71,968	35,688	1,099,716		1,099,716		1,099,716			1
2	Food Purchase		767,154		767,154		767,154	(27,328)	739,826			2
3	Housekeeping	396,850	134,866		531,716		531,716		531,716			3
4	Laundry	91,535	551,825	252	643,612		643,612		643,612			4
5	Heat and Other Utilities			364,153	364,153		364,153		364,153			5
6	Maintenance	587,126	236,995	167,148	991,269		991,269	(71,776)	919,493			6
7	Other (specify):*											7
8	TOTAL General Services	2,067,571	1,762,808	567,241	4,397,620		4,397,620	(99,104)	4,298,516			8
	B. Health Care and Programs											
9	Medical Director			17,400	17,400		17,400		17,400			9
10	Nursing and Medical Records	6,556,273	475,213	954,952	7,986,438		7,986,438		7,986,438			10
10a	Therapy	128,985			128,985		128,985		128,985			10a
11	Activities	316,018	3,517	3,016	322,551		322,551		322,551			11
12	Social Services	167,024	1,378	1,440	169,842		169,842		169,842			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	7,168,300	480,108	976,808	8,625,216		8,625,216		8,625,216			16
	C. General Administration											
17	Administrative	170,080		400,463	570,543		570,543	(45,606)	524,937			17
18	Directors Fees											18
19	Professional Services			209,816	209,816		209,816	(13,605)	196,211			19
20	Dues, Fees, Subscriptions & Promotions			23,773	23,773		23,773		23,773			20
21	Clerical & General Office Expenses	196,097	39,744	112,734	348,575		348,575	(70,808)	277,767			21
22	Employee Benefits & Payroll Taxes			1,599,497	1,599,497		1,599,497	4,280,196	5,879,693			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,685	6,685		6,685		6,685			24
25	Other Admin. Staff Transportation			5,655	5,655		5,655		5,655			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	TOTAL General Administration	366,177	39,744	2,358,623	2,764,544		2,764,544	4,150,177	6,914,721			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	9,602,048	2,282,660	3,902,672	15,787,380		15,787,380	4,051,073	19,838,453			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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			456,829	456,829		456,829	14,210	471,039			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			46,422	46,422		46,422	(2,574)	43,848			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			76,656	76,656		76,656		76,656			35
36	Other (specify):*			212,200	212,200		212,200	(212,200)				36
37	TOTAL Ownership			792,107	792,107		792,107	(200,564)	591,543			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		81,701	621,516	703,217		703,217		703,217			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			659,239	659,239		659,239		659,239			42
43	Other (specify):*			20,000	20,000		20,000	(20,000)				43
44	TOTAL Special Cost Centers		81,701	1,300,755	1,382,456		1,382,456	(20,000)	1,362,456			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	9,602,048	2,364,361	5,995,534	17,961,943		17,961,943	3,830,509	21,792,452			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(27,328)	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	14,210	30		9
10	Interest and Other Investment Income	(2,574)	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				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	(374,784)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (390,476)		\$	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 Amount	2 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)	4,220,985		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 4,220,985		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ 3,830,509		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 Yes	2 No	3 Amount	4 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	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Uniform Fees	\$ (510)	21	1
2	Transfers to Other Funds	(212,200)	36	2
3	Other Unclassified Income	(69,798)	21	3
4	Election Expense	(500)	21	4
5	Capitalized R&M	(71,776)	06	5
6	Non Allowable Expense	(20,000)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(374,784)		49

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	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/15 Ending: 09/30/16

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	(27,328)											(27,328)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(71,776)											(71,776)	6
7	Other (specify):*													7
8	TOTAL General Services	(99,104)											(99,104)	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(45,606)									(45,606)	17
18	Directors Fees													18
19	Professional Services			(13,605)									(13,605)	19
20	Fees, Subscriptions & Promotions													20
21	Clerical & General Office Expenses	(70,808)											(70,808)	21
22	Employee Benefits & Payroll Taxes		4,280,196										4,280,196	22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(70,808)	4,280,196	(59,211)									4,150,177	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(169,912)	4,280,196	(59,211)									4,051,073	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/15 Ending: 09/30/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	14,210											14,210	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,574)											(2,574)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*	(212,200)											(212,200)	36
37	TOTAL Ownership	(200,564)											(200,564)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(20,000)											(20,000)	43
44	TOTAL Special Cost Centers	(20,000)											(20,000)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(390,476)	4,280,196	(59,211)									3,830,509	45

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:	
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	22	Emp Benefits IMRF	\$	Winnebago County	100.00%	\$ 885,752	\$ 885,752	1
2	V	22	Medicare Payroll Taxes		Winnebago County	100.00%	135,198	135,198	2
3	V	22	Payroll Taxes		Winnebago County	100.00%	578,086	578,086	3
4	V	22	Workers Comp		Winnebago County	100.00%	2,658,280	2,658,280	4
5	V	22	Unemployment Taxes		Winnebago County	100.00%	22,880	22,880	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			\$			\$ 4,280,196	\$ * 4,280,196	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	County Auditor	\$	Winnebago County	100.00%	\$ 24,150	\$ 24,150	15
16	V	17	County Board		Winnebago County	100.00%	69,024	69,024	16
17	V	17	County Treasurer		Winnebago County	100.00%	61,549	61,549	17
18	V	17	Human Resources		Winnebago County	100.00%	49,667	49,667	18
19	V	17	Purchasing		Winnebago County	100.00%	17,834	17,834	19
20	V	17	States Attorney - Civil		Winnebago County	100.00%	76,904	76,904	20
21	V	17	States Attorney - Bruscato		Winnebago County	100.00%	20,717	20,717	21
22	V	17	County Finance		Winnebago County	100.00%	35,012	35,012	22
23	V	19	Audit & Accounting		Winnebago County	100.00%	16,395	16,395	23
24	V	17	Administrative	400,463	Winnebago County	100.00%		(400,463)	24
25	V								25
26	V								26
27	V	19	Data Processing	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	Total			\$ 430,463			\$ 371,252	\$ * (59,211)	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	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	Total			\$			\$	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/15 Ending: 09/30/16

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	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										2
3	Conducted Business Transactions With The Nursing Home During The Reporting Period										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: 10/01/15 Ending: 09/30/16

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 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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	22	Emp Benefits IMRF	Direct Cost	91,137,172	11	\$ 885,752	\$	91,137,172	\$ 885,752	1
2	22	Medicare Payroll Taxes	Direct Cost	91,137,172	11	135,198		91,137,172	135,198	2
3	22	Payroll Taxes	Direct Cost	91,137,172	11	578,086		91,137,172	578,086	3
4	22	Workers Comp	Direct Cost	91,137,172	11	2,658,280		91,137,172	2,658,280	4
5	22	Unemployment Taxes	Direct Cost	91,137,172	11	22,880		91,137,172	22,880	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					\$ 4,280,196	\$		\$ 4,280,196	25

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/15 Ending: 09/30/16

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 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

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	County Auditor	Operating Expense	91,137,172	11	\$ 200,799	\$ 176,717	10,961,173	\$ 24,150	1
2	17	County Board	Operating Expense	91,137,172	11	573,903	503,253	10,961,173	69,024	2
3	17	County Treasurer	Operating Expense	91,137,172	11	511,749	311,889	10,961,173	61,549	3
4	17	Human Resources	Operating Expense	91,137,172	11	412,957	341,572	10,961,173	49,667	4
5	17	Purchasing	Operating Expense	91,137,172	11	148,286	125,079	10,961,173	17,834	5
6	17	States Attorney - Civil	Operating Expense	91,137,172	11	639,418	539,809	10,961,173	76,904	6
7	17	States Attorney - Bruscato	Operating Expense	91,137,172	11	172,250	172,250	10,961,173	20,717	7
8	17	County Finance	Operating Expense	91,137,172	11	291,105	217,401	10,961,173	35,012	8
9	17	Audit & Accounting	Operating Expense	91,137,172	11	136,315		10,961,173	16,395	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					\$ 3,086,781	\$ 2,387,970		\$ 371,252	25

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/01/15 Ending: 09/30/16

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: 10/01/15 Ending: 09/30/16

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: 10/01/15 Ending: 09/30/16

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: 10/01/15 Ending: 09/30/16

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: 10/01/15 Ending: 09/30/16

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: 10/01/15 Ending: 09/30/16

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: 10/01/15 Ending: 09/30/16

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: 10/01/15 Ending: 09/30/16

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	County Bond		X	Construction			\$				\$	46,422	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6													6
7													7
8					-								8
9	TOTAL Facility Related						\$				\$	46,422	9
	B. Non-Facility Related*												
10	Interest Income											(2,574)	10
11													11
12													12
13					-								13
14	TOTAL Non-Facility Related						\$				\$	(2,574)	14
15	TOTALS (line 9+line14)						\$				\$	43,848	15

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

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

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
6													6
7	TOTAL Long-Term												7
	Working Capital												
8							\$					\$	8
9													9
10													10
11													11
12													12
13													13
14	TOTAL Working Capital												14
	B. Non-Facility Related*												
15							\$					\$	15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

2015 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) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(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.		\$	\$
TOTALS		\$	\$

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
 RE: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

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

2015 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) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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 Steel	Number of Stories	1
------------------------	----------------	--------------------------------------	-----------------------	------------------------------------	--------------------------	----------

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

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

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

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

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

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

N/A

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

1. Total Amount Incurred:	2. Number of Years Over Which it is Being Amortized:
----------------------------------	---

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	3,277,019	1971	\$ 5,830	1
2					2
3	TOTALS	3,277,019		\$ 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	
	Improvement Type**											
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	5,583	5,583		15,999	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	1,262	1,262		27,811	28	
29	Various		1997	117,237		20	5,862	5,862		114,307	29	
30	Various		1998	19,029		20	744	744		17,913	30	
31	Various		1999	48,763		20	2,127	2,127		43,447	31	
32	Various		2000	88,615		20	4,742	4,742		78,244	32	
33	Various		2001	113,136		20	5,657	5,657		44,946	33	
34	Various		2002	379,998		20	19,000	19,000		275,499	34	
35	Various		2003	300,474		20	15,024	15,024		200,535	35	
36	Various		2004	1,617,574		20	76,895	76,895		1,040,863	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:

10/01/15

Ending:

09/30/16

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	\$ 55,577	37
38 Various	2006	272,911		20	13,646	13,646	143,279	38
39 Various	2007	136,310		20	6,816	6,816	64,750	39
40 Various	2008	56,319		20	2,816	2,816	21,959	40
41 Various	2009	46,742		20	2,337	2,337	13,893	41
42 Various	2010	665,059		20	33,253	33,253	232,475	42
43 Various	2011	77,034		20	3,851	3,851	26,020	43
44 Various	2012	197,175		20	9,858	9,858	49,121	44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70								70
Related Building Company (Pages 12F & 12G)								
Related Party Allocations (Pages 12H & 12I)								
Financial Statement Depreciation			456,829			(456,829)		
TOTAL (lines 4 thru 69)		\$ 8,990,748	\$ 456,829		\$ 214,304	\$ (242,524)	\$ 7,207,246	

**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:

10/01/15

Ending:

09/30/16

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	Totals from Page 12A, Carried Forward		\$ 8,990,748	\$ 456,829		\$ 214,304	\$ (242,524)	\$ 7,207,246	1
2	Water Softner	2013	41,087		20	2,054	2,054	8,216	2
3	Install 6 Ip Cameras In Kitchen	2013	14,986		20	749	749	2,996	3
4	Repair Heating And Cooling Unit #6	2013	14,321		20	716	716	2,864	4
5	Repair Air Handler Unit # 2	2013	15,034		20	752	752	3,008	5
6	Replace 278 Closet Doors	2013	8,896		20	445	445	1,780	6
7	Repair Air Handler Unit #9	2013	9,640		20	482	482	1,928	7
8	D- Wing: Fabricated & Installed Protective Stainless Steel Panes F	2013	6,574		20	329	329	1,316	8
9	Abatement And Disposal Of Asbestos Ceiling Tile	2013	9,580		20	479	479	1,916	9
10	Repair Chiller Cooling Tower	2013	5,234		20	262	262	1,048	10
11	Dove Wing: Shower Room- New Tile On Walls And Floor	2013	4,500		20	225	225	900	11
12	Cardinal Wing: Shower Room- New Tile On Walls And Floor	2013	4,500		20	225	225	900	12
13	Repair Air Handler Unit #9	2013	5,590		20	279	279	1,116	13
14	Repair Concrete Sidewalk	2013	7,500		20	375	375	1,500	14
15	Sprinkler System	2014	3,025,124		20	151,256	151,256	453,769	15
16	Cooling Coil Replacement	2014	13,990		20	700	700	2,099	16
17	Heating Valve Replacement	2014	13,850		20	693	693	2,078	17
18	Heating Coil Replacement	2014	16,400		20	820	820	2,460	18
19	Oxygen Storage Pipe	2014	13,260		20	663	663	1,989	19
20	Air System Compressor	2014	24,680		20	1,234	1,234	3,702	20
21	New Carpet Tile For The Facility Entrance Way	2014	5,050		20	253	253	758	21
22	Repaired/Replaced 15 Damper Assemblies	2014	4,165		20	208	208	625	22
23	Air Handler Unit #3, D Wing- Repairs	2014	14,273		20	714	714	2,141	23
24	New Chiller	2014	4,308		20	215	215	646	24
25	Gravel For Landscaping	2014	13,125		20	656	656	1,969	25
26	Repair Cooling System- Air Handler Not Functioning	2014	24,680		20	1,234	1,234	3,702	26
27	Fire Damper Repairs	2014	14,965		20	748	748	2,245	27
28	New Water Heater	2014	8,308		20	415	415	1,246	28
29	Replaced Heating Coil In Air Handler #2	2014	16,400		20	820	820	2,460	29
30	Removed And Repaired Cooling Coil	2014	11,270		20	564	564	1,691	30
31	Replaced Oxygen Storage Piping	2014	13,260		20	663	663	1,989	31
32	Supply & Install Interior Logo, Illuminated Single Sided Sign	2015	14,280		20	714	714	1,428	32
33	Replaced Compressor	2015	9,875		20	494	494	988	33
34	TOTAL (lines 1 thru 33)		\$ 12,399,452	\$ 456,829		\$ 384,740	\$ (72,089)	\$ 7,724,716	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:

10/01/15

Ending:

09/30/16

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	Totals from Page 12B, Carried Forward		\$ 12,399,452	\$ 456,829		\$ 384,740	\$ (72,089)	\$ 7,724,716	1
2	Installed,Piped, And Wired Dish Sink Disposal	2015	7,907		20	395	395	791	2
3	Install New Bullhorns/Tenons/Ballast On 2-North Parking Lot Lig	2015	2,855		20	143	143	143	3
4	Design/Fabricate Registers For Dining/Patient Rooms. Install New	2015	5,285		20	264	264	264	4
5	Ups System Pathway Lights/Neighborhood Em Lights	2016	11,200		20	560	560	560	5
6	Generator Repair	2016	153,800		20	7,690	7,690	7,690	6
7	Overhaul Trane Centrifugal Chiller & Bearings	2016	51,235		20	2,562	2,562	2,562	7
8	Provide & Install New Heating Coil In Maintenance Area	2016	4,238		20	212	212	212	8
9	Circulating Taco Pump Bldg. A	2016	7,182		20	359	359	359	9
10	Repipe Under Sink Lines, Install Mixing Valves/New Faucet	2016	3,854		20	193	193	193	10
11	Bonnet/Valve/Dial Repair	2016	4,537		20	227	227	227	11
12	Check/Install New Garbage Disposal	2016	3,381		20	169	169	169	12
13	New Chiller Motor	2016	9,385		20	469	469	469	13
14	Replace,Program,Startup, And Commission Cooling Tower Frequ	2016	4,741		20	237	237	237	14
15	Installation Of Tank	2016	6,724		20	336	336	336	15
16	Electrical Repairs	2016	6,040		20	302	302	302	16
17	Magnaflux, Pressure Test & Resurface Cylinder Heads	2016	6,095		20	305	305	305	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)		\$ 12,687,912	\$ 456,829		\$ 399,162	\$ (57,666)	\$ 7,739,534	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 Totals from Page 12C, Carried Forward		\$ 12,687,912	\$ 456,829		\$ 399,162	\$ (57,666)	\$ 7,739,534	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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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)		\$ 12,687,912	\$ 456,829		\$ 399,162	\$ (57,666)	\$ 7,739,534	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	Totals from Page 12D, Carried Forward		\$12,687,912	\$456,829		\$399,162	\$ (57,666)	\$7,739,534	1
2									2
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$12,687,912	\$456,829		\$399,162	\$ (57,666)	\$7,739,534	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:

10/01/15

Ending:

09/30/16

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	Building Company		\$	\$		\$	\$	\$	1
2									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	TOTAL (lines 1 thru 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	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	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)		\$	\$		\$	\$	\$	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	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	TOTAL (lines 1 thru 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	Totals from Page 12H, Carried Forward		\$	\$		\$	\$	\$	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)		\$	\$		\$	\$	\$	34

**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	\$476,102	\$	\$42,122	\$42,122	10	\$210,085	71
72	Current Year Purchases	32,325		3,233	3,233	10	3,233	72
73	Fully Depreciated Assets	1,393,289				10	1,393,289	73
74								74
75	TOTALS	\$1,901,716	\$	\$45,355	\$45,355		\$1,606,607	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	95,331	79
80	TOTALS			\$235,099	\$	\$26,522	\$26,522		\$169,822	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)	\$14,830,557	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$456,829	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$471,039	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$14,210	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$9,515,963	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: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

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

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

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

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

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

15. Is Movable equipment rental included in building rental?
- ☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 76,656
- 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	TOTAL		\$ -	\$	21

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 154,113	\$		\$ 154,113	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			87,452			87,452	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			368,031			368,031	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				81,701		81,701	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					11,920			11,920	13
14	TOTAL			\$		\$ 621,516	\$ 81,701		\$ 703,217	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*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 5,474	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	5,980,910		3
4	Supply Inventory (priced at)	105,209		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>	1,912,329		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 8,003,922	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	5,830		13
14	Buildings, at Historical Cost	4,487,780		14
15	Leasehold Improvements, at Historical Cost	7,745,856		15
16	Equipment, at Historical Cost	2,166,358		16
17	Accumulated Depreciation (book methods)	(9,149,440)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	72,710		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>	2,173,603		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,502,697	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 15,506,619	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,255,238	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	527,287		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	8,710		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule</u>	7,905,472		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,696,707	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Attached Schedule</u>	168,267		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 168,267	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,864,974	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 5,641,645	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 15,506,619	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 9,559,350	1
2	Restatements (describe):		2
3	Equity Adjustment	(942,246)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 8,617,104	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,975,459)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (2,975,459)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 5,641,645	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number River Bluff Nursing Home

0005611

Report Period Beginning: 10/01/15

Ending:

09/30/16

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 14,658,869	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,658,869	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	911	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	27,328	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 28,239	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,574	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,574	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	296,802	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 296,802	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 14,986,484	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	4,397,620	31
32	Health Care	8,625,216	32
33	General Administration	2,764,544	33
	B. Capital Expense		
34	Ownership	792,107	34
	C. Ancillary Expense		
35	Special Cost Centers	723,217	35
36	Provider Participation Fee	659,239	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 17,961,943	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,975,459)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,975,459)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 9,246,899	44
45	Private Pay - Net Inpatient Revenue	3,774,683	45
46	Medicare - Net Inpatient Revenue	951,661	46
47	Other-(specify) <u>Hospice</u>	685,626	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,658,869	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.

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	1,768	2,080	\$ 105,142	\$ 50.55	1
2	Assistant Director of Nursing	1,774	2,024	92,644	45.77	2
3	Registered Nurses	69,008	79,186	2,400,123	30.31	3
4	Licensed Practical Nurses	53,152	60,328	1,687,686	27.98	4
5	CNAs & Orderlies	134,939	153,321	2,099,613	13.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,538	7,473	128,985	17.26	8
9	Activity Director	1,829	2,080	44,747	21.51	9
10	Activity Assistants	18,326	21,268	271,271	12.75	10
11	Social Service Workers	9,404	10,439	167,024	16.00	11
12	Dietician					12
13	Food Service Supervisor	1,808	2,083	54,858	26.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	53,115	59,743	736,545	12.33	15
16	Dishwashers	20,470	22,596	200,657	8.88	16
17	Maintenance Workers	22,830	26,499	587,126	22.16	17
18	Housekeepers	27,226	30,660	396,850	12.94	18
19	Laundry	1,759	2,080	91,535	44.01	19
20	Administrator	1,748	2,080	96,706	46.49	20
21	Assistant Administrator	1,797	2,080	73,374	35.28	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,916	13,431	196,097	14.60	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	11,165	12,786	171,065	13.38	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	450,572	512,237	\$ 9,602,048 *	\$ 18.75	34

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	839	\$ 35,688	01-03	35
36	Medical Director	Monthly	17,400	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	2,160	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	1,884	11-03	44
45	Social Service Consultant	Monthly	1,440	12-03	45
46	Other(specify) <u>Chaplain</u>	Monthly	1,132	11-03	46
47	<u>Medical & Dental Consultant</u>	Monthly	67	10-03	47
48					48
49	TOTAL (lines 35 - 48)	839	\$ 59,771		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,378	\$ 99,083	10-03	50
51	Licensed Practical Nurses	5,936	211,505	10-03	51
52	Certified Nurse Assistants/Aides	34,046	642,137	10-03	52
53	TOTAL (lines 50 - 52)	42,360	\$ 952,725		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number		River Bluff Nursing Home		STATE OF ILLINOIS		# 0005611		Report Period Beginning:		10/01/15		Page 21		Ending:		09/30/16			
XIX. SUPPORT SCHEDULES																			
A. Administrative Salaries				Ownership				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions							
Name		Function		%		Amount		Description		Amount		Description		Amount					
Pamela Gentner		Administrator		0		\$ 96,706		Workers' Compensation Insurance		\$ 2,658,280		IDPH License Fee		\$					
Monica Plymale		Asst. Admin.		0		73,374		Unemployment Compensation Insurance		22,880		Advertising: Employee Recruitment		10,068					
								FICA Taxes		713,284		Health Care Worker Background Check							
								Employee Health Insurance		1,594,420		(Indicate # of checks performed 165.6)		5,274					
								Employee Meals				Patient Background Checks							
								Illinois Municipal Retirement Fund (IMRF)*		885,752		Dues & Subscriptions		1,031					
								Employee Assistance		5,076		Licenses & Permits		6,295					
TOTAL (agree to Schedule V, line 17, col. 1)																			
(List each licensed administrator separately.)				\$ 170,080															
B. Administrative - Other																			
Description						Amount													
Winnebago County						\$ 400,463													
TOTAL (agree to Schedule V, line 17, col. 3)						\$ 400,463													
(Attach a copy of any management service agreement)																			
C. Professional Services																			
Vendor/Payee		Type		Amount		Description		Line #		Amount		Description		Amount					
FR&R/Marcum LLP		Accounting/Auditing		\$ 13,698						\$		Out-of-State Travel		\$					
Duane Morris		Legal		44,535															
Hinshaw & Culbertson		Legal		936															
Mark D. Olson, CPA Ltd.		Accounting		6,198								In-State Travel							
National Government Services		Health Solutions		60,588															
Winnebago County		Data Processing		30,000															
Aj Gallagher		Employee Benefits/Risk		1,320															
Wescom Solutions Inc		Data Processing Consulting		42,152								Seminar Expense		6,685					
Jumping Trout		Data Processing		365															
Furst Staffing		Employee Recruitment		10,026															
TOTAL (agree to Schedule V, line 19, column 3)								TOTAL				\$							
(For legal fee disclosure, see page 39 of instructions)				\$ 209,816															
* Attach copy of IMRF notifications																			
**See instructions.																			

Facility Name & ID Number <u>River Bluff Nursing Home</u>	STATE OF ILLINOIS # <u>0005611</u>	Report Period Beginning: <u>10/01/15</u>	Ending: <u>09/30/16</u>
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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. \$ 62,571 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. \$ 659,239
 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. \$ 27,327

(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 1
 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