FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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 Street (Number) Rockford (City) 61103 (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		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: TJ Ely **Telephone Number:** (216) 274-6586
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 10/1/17 to 9/30/18 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)
(Print Name and Title) TJ Ely, Manager
(Firm Name & Address) Plante & Moran, PLLC, 1111 Superior Ave, Suite 1250, Cleveland, OH 44114
(Telephone) (216) 274-6586 Fax # (248) 327-8492

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: 10/1/17 Ending: 9/30/18

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	783		1,808	2,591	8
9	SNF/PED					9
10	ICF	57,766	6,868	389	65,023	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,549	6,868	2,197	67,614	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.94%

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 [X]

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

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 [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 152 and days of care provided 2,591

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/2018 Fiscal Year: 9/30/2018

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	780,560	48,020	30,696	859,276		859,276		859,276			1
2	Food Purchase		727,460		727,460		727,460		727,460			2
3	Housekeeping	244,875	66,723		311,598		311,598		311,598			3
4	Laundry	15,236	464,416		479,652		479,652		479,652			4
5	Heat and Other Utilities			383,568	383,568		383,568		383,568			5
6	Maintenance		308,736		308,736		308,736		308,736			6
7	Other (specify):*			22,605	22,605		22,605		22,605			7
8	**TOTAL General Services**	1,040,671	1,615,355	436,869	3,092,895		3,092,895		3,092,895			8
	B. Health Care and Programs											
9	Medical Director			17,400	17,400		17,400		17,400			9
10	Nursing and Medical Records	4,863,038	421,383	1,005,470	6,289,891		6,289,891		6,289,891			10
10a	Therapy			555,152	555,152		555,152		555,152			10a
11	Activities	223,831	3,200	3,168	230,199		230,199		230,199			11
12	Social Services	167,417		984	168,401		168,401		168,401			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,254,286	424,583	1,582,174	7,261,043		7,261,043		7,261,043			16
	C. General Administration											
17	Administrative	274,385		969,101	1,243,486		1,243,486	(463,013)	780,473			17
18	Directors Fees											18
19	Professional Services			501,543	501,543		501,543	11,778	513,321			19
20	Dues, Fees, Subscriptions & Promotions			28,120	28,120		28,120		28,120			20
21	Clerical & General Office Expenses	686,492	50,709	209,851	947,052		947,052	(155,275)	791,777			21
22	Employee Benefits & Payroll Taxes			1,952,624	1,952,624		1,952,624	1,743,857	3,696,481			22
23	Inservice Training & Education											23
24	Travel and Seminar			28,158	28,158		28,158		28,158			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	960,877	50,709	3,689,397	4,700,983		4,700,983	1,137,347	5,838,330			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	7,255,834	2,090,647	5,708,440	15,054,921		15,054,921	1,137,347	16,192,268			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number River Bluff Nursing Home #0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			447,469	447,469		447,469		447,469			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,478	25,478		25,478		25,478			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			64,915	64,915		64,915		64,915			35
36	Other (specify):*											36
37	**TOTAL Ownership**			537,862	537,862		537,862		537,862			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		7,809		7,809		7,809		7,809			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			566,696	566,696		566,696		566,696			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		7,809	566,696	574,505		574,505		574,505			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,255,834	2,098,456	6,812,998	16,167,288		16,167,288	1,137,347	17,304,635			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: 10/1/17 Ending: 9/30/18

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(155,275)	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				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (155,275)		$	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)	1,292,622	VII-B	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,292,622		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,137,347		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

River Bluff Nursing Home

ID# 0005611

Report Period Beginning: 10/1/17

Ending: 9/30/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living	$ 0	43	1
2	Non-Allowable Benefits (Marketing & ILU)	0	22	2
3		0		3
4		0		4
5		0		5
6		0		6
7		0		7
8		0		8
9		0		9
10		0		10
11		0		11
12		0		12
13		0		13
14		0		14
15		0		15
16		0		16
17		0		17
18		0		18
19		0		19
20		0		20
21		0		21
22		0		22
23		0		23
24		0		24
25		0		25
26		0		26
27		0		27
28		0		28
29		0		29
30		0		30
31		0		31
32		0		32
33		0		33
34		0		34
35		0		35
36		0		36
37		0		37
38		0		38
39		0		39
40		0		40
41		0		41
42		0		42
43		0		43
44		0		44
45		0		45
46		0		46
47		0		47
48		0		48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(463,013)	0	0	0	0	0	0	0	0	(463,013)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	11,778	0	0	0	0	0	0	0	0	11,778	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(155,275)	0	0	0	0	0	0	0	0	0	0	(155,275)	21
22	Employee Benefits & Payroll Taxes	0	1,743,857	0	0	0	0	0	0	0	0	0	1,743,857	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(155,275)	1,743,857	(451,235)	0	0	0	0	0	0	0	0	1,137,347	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(155,275)	1,743,857	(451,235)	0	0	0	0	0	0	0	0	1,137,347	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(155,275)	1,743,857	(451,235)	0	0	0	0	0	0	0	0	1,137,347	45

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	22	Emp Benefits IMRF	$	Winnebago County	100.00%	$ 670,930	$ 670,930	1
2	V	22	Medicare Payroll Taxes		Winnebago County	100.00%	109,627	109,627	2
3	V	22	Payroll Taxes		Winnebago County	100.00%	468,257	468,257	3
4	V	22	Workers Comp		Winnebago County	100.00%	477,716	477,716	4
5	V	22	Unemployment Taxes		Winnebago County	100.00%	17,327	17,327	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			$			$ 1,743,857	$ * 1,743,857	14

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	County Auditor	$	Winnebago County	100.00%	$ 17,957	$ 17,957	15
16	V	17	County Board		Winnebago County	100.00%	62,233	62,233	16
17	V	17	County Treasurer		Winnebago County	100.00%	41,424	41,424	17
18	V	17	Human Resources		Winnebago County	100.00%	32,108	32,108	18
19	V	17	Purchasing		Winnebago County	100.00%	16,810	16,810	19
20	V	17	States Attorney - Civil		Winnebago County	100.00%	69,839	69,839	20
21	V	17	States Attorney - Bruscato		Winnebago County	100.00%	15,820	15,820	21
22	V	17	County Finance		Winnebago County	100.00%	21,645	21,645	22
23	V	19	Audit and Accounting		Winnebago County	100.00%	13,266	11,778	23
24	V	17	Administrative	980,000	Winnebago County	100.00%		(980,000)	24
25	V	17	Data Processing		Winnebago County	100.00%	108,740	108,740	25
26	V	17	Bldg/Maint Personnel		Winnebago County	100.00%	130,411	130,411	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			$ 980,000			$ 530,253	$ * (451,235)	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: 10/1/17 Ending: 9/30/18

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: 10/1/17 Ending: 9/30/18

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: 10/1/17 Ending: 9/30/18

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Emp Benefits IMRF	Direct Cost	187,354,320	11	$ 670,930	$	187,354,320	$ 670,930	1
2	22	Medicare Payroll Taxes	Direct Cost	187,354,320	11	109,627		187,354,320	109,627	2
3	22	Payroll Taxes	Direct Cost	187,354,320	11	468,257		187,354,320	468,257	3
4	22	Workers Comp	Direct Cost	187,354,320	11	477,716		187,354,320	477,716	4
5	22	Unemployment Taxes	Direct Cost	187,354,320	11	17,327		187,354,320	17,327	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					$ 1,743,857	$		$ 1,743,857	25

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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 [X] NO [ ]

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

Name of Related Organization: County of Winnebago
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Phone Number: (815) 319-4055
Fax Number: (815) 319-4051

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	County Auditor	Operating Expense	187,354,320	11	$ 189,152	$ 184,902	17,786,158	$ 17,957	1
2	17	County Board	Operating Expense	187,354,320	11	655,541	617,380	17,786,158	62,233	2
3	17	County Treasurer	Operating Expense	187,354,320	11	436,345	292,922	17,786,158	41,424	3
4	17	Human Resources	Operating Expense	187,354,320	11	338,217	307,873	17,786,158	32,108	4
5	17	Purchasing	Operating Expense	187,354,320	11	177,069	171,664	17,786,158	16,810	5
6	17	States Attorney - Civil	Operating Expense	187,354,320	11	735,661	568,500	17,786,158	69,839	6
7	17	States Attorney - Bruscato	Operating Expense	187,354,320	11	166,646	166,646	17,786,158	15,820	7
8	17	County Finance	Operating Expense	187,354,320	11	228,000	222,377	17,786,158	21,645	8
9	19	Audit and Accounting	Operating Expense	187,354,320	11	124,063		17,786,158	11,778	9
10	17	Data Processing	Operating Expense	187,354,320	11	1,145,439	733,295	17,786,158	108,740	10
11	17	Bldg/Maint Personnel	Operating Expense	187,354,320	11	1,373,708	1,268,664	17,786,158	130,411	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					$ 5,569,841	$ 4,534,223		$ 528,765	25

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	Series 2012A Bonds			$	$			$ 25,503	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 25,503	9
	B. Non-Facility Related*											
10	Interest Income										(25)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (25)	14
15	TOTALS (line 9+line14)						$	$			$ 25,478	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.)

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost 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. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2012		8
2013		9
2014		10
2015		11
2016		12

Not Applicable to the Facility

	FOR BHF USE ONLY		
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.

2017 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 Denise Gadomski

TELEPHONE (216) 274-6514 FAX #: (248) 233-7349

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

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) 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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 10/1/17 Ending: 9/30/18

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).

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:

A. Land.

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 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			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			117,237	29
30	Various			1998	19,029		20	372	372	19,029	30
31	Various			1999	48,763		20	2,438	2,438	48,012	31
32	Various			2000	88,615		20	4,431	4,431	87,417	32
33	Various			2001	113,136		20	5,657	5,657	56,260	33
34	Various			2002	379,998		20	19,000	19,000	313,499	34
35	Various			2003	300,474		20	15,024	15,024	230,583	35
36	Various			2004	1,617,574		20	80,879	80,879	1,198,637	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	
37	Various	2005	$ 81,119	$	20	$ 4,056	$ 4,056	$ 64,466	37
38	Various	2006	272,911		20	13,646	13,646	170,570	38
39	Various	2007	136,310		20	6,816	6,816	78,381	39
40	Various	2008	56,319		20	2,816	2,816	27,591	40
41	Various	2009	46,742		20	2,337	2,337	18,567	41
42	Various	2010	665,059		20	33,253	33,253	298,981	42
43	Various	2011	77,034		20	3,852	3,852	33,724	43
44	Various	2012	197,175		20	9,859	9,859	68,839	44
45	Various	2013	147,442		20	7,372	7,372	44,232	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			447,469			(447,469)		69
70	TOTAL (lines 4 thru 69)		$ 9,138,190	$ 447,469		$ 211,807	$ (235,662)	$ 7,649,278	70

**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: 10/1/17 Ending: 9/30/18

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 12A, Carried Forward		$ 9,138,190	$ 447,469		$ 211,807	$ (235,662)	$ 7,649,278	1
2	Sprinkler System	2014	3,025,124		20	151,256	151,256	756,281	2
3	Cooling Coil Replacement	2014	13,990		20	700	700	3,498	3
4	Heating Valve Replacement	2014	13,850		20	693	693	3,463	4
5	Heating Coil Replacement	2014	16,400		20	820	820	4,100	5
6	Oxygen Storage Pipe	2014	13,260		20	663	663	3,315	6
7	Air System Compressor	2014	24,680		20	1,234	1,234	6,170	7
8	New Carpet Tile For The Facility Entrance Way	2014	5,050		20	253	253	1,263	8
9	Repaired/Replaced 15 Damper Assemblies	2014	4,165		20	208	208	1,041	9
10	Air Handler Unit #3, D Wing- Repairs	2014	14,273		20	714	714	3,569	10
11	New Chiller	2014	4,308		20	215	215	1,077	11
12	Gravel For Landscaping	2014	13,125		20	656	656	3,281	12
13	Repair Cooling System- Air Handler Not Functioning	2014	24,680		20	1,234	1,234	6,170	13
14	Fire Damper Repairs	2014	14,965		20	748	748	3,741	14
15	New Water Heater	2014	8,308		20	415	415	2,077	15
16	Replaced Heating Coil In Air Handler #2	2014	16,400		20	820	820	4,100	16
17	Removed And Repaired Cooling Coil	2014	11,270		20	564	564	2,818	17
18	Replaced Oxygen Storage Piping	2014	13,260		20	663	663	3,315	18
19	Supply & Install Interior Logo, Illuminated Single Sided Sign	2015	14,280		20	714	714	2,856	19
20	Replaced Compressor	2015	9,875		20	494	494	1,975	20
21	Installed,Piped, And Wired Dish Sink Disposal	2015	7,907		20	395	395	1,581	21
22	Install New Bullhorns/Tenons/Ballast On 2-North Parking Lot Lig	2015	2,855		20	143	143	429	22
23	Design/Fabricate Registers For Dining/Patient Rooms. Install New	2015	5,285		20	264	264	792	23
24	Ups System Pathway Lights/Neighborhood Em Lights	2016	11,200		20	560	560	1,680	24
25	Generator Repair	2016	153,800		20	7,690	7,690	23,070	25
26	Overhaul Trane Centrifugal Chiller & Bearings	2016	51,235		20	2,562	2,562	7,686	26
27	Provide & Install New Heating Coil In Maintenance Area	2016	4,238		20	212	212	636	27
28	Circulating Taco Pump Bldg. A	2016	7,182		20	359	359	1,077	28
29	Repipe Under Sink Lines, Install Mixing Valves/New Faucet	2016	3,854		20	193	193	578	29
30	Bonnet/Valve/Dial Repair	2016	4,537		20	227	227	681	30
31	Check/Install New Garbage Disposal	2016	3,381		20	169	169	507	31
32	New Chiller Motor	2016	9,385		20	469	469	1,408	32
33	Replace,Program,Startup, And Commission Cooling Tower Frequ	2016	4,741		20	237	237	711	33
34	TOTAL (lines 1 thru 33)		$ 12,669,053	$ 447,469		$ 388,350	$ (59,119)	$ 8,504,223	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: 10/1/17 Ending: 9/30/18

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 12B, Carried Forward		$ 12,669,053	$ 447,469		$ 388,350	$ (59,119)	$ 8,504,223	1
2	Installation Of Tank	2016	6,724		20	336	336	1,008	2
3	Electrical Repairs	2016	6,040		20	302	302	906	3
4	Magnaflux, Pressure Test & Resurface Cylinder Heads	2016	6,095		20	305	305	915	4
5	Change Hot Water Cir Pump In C-Wing	2016	2,903		20	145	145	290	5
6	Swap Out Gas And Diesel Pump	2017	2,500		20	125	125	250	6
7	Replace 7 Fire Damper Actuators	2017	4,525		20	226	226	452	7
8	Boiler Repair - Replace Gas Valve Body And Actuator	2017	4,980		20	249	249	498	8
9	Plumbing Work - Install Pump In E-Wing Pump #2	2017	2,936		20	147	147	294	9
10	Change Hot Water Cir Pump In D-Wing	2017	2,936		20	147	147	294	10
11	Excavation And Blacktop - Asphalt Paving	2017	4,672		20	234	234	468	11
12	Replace Dishroom Door	2017	6,609		20	330	330	660	12
13	B-2/B-4 Shower Rooms - Patch/Caulk Wall & Floor Tile, Install C	2017	4,374		20	219	219	438	13
14	Shower Rooms C-2,C-4,D-2,D-4 - Remove Framing, Plywood, Tile	2017	6,196		20	310	310	620	14
15	Install Additional Door In Basement	2017	3,309		20	165	165	330	15
16	Installation Of 3 Fixed Dome/360 Degree Cameras On Patio	2017	10,982		20	549	549	1,098	16
17	Blast Chiller	2018	26,153		20	545	545	545	17
18	Steamer-Convection	2018	23,727		20	395	395	395	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)		$ 12,794,714	$ 447,469		$ 393,079	$ (54,390)	$ 8,513,684	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: 10/1/17 Ending: 9/30/18

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 12C, Carried Forward		$ 12,794,714	$ 447,469		$ 393,079	$ (54,390)	$ 8,513,684	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
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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)		$ 12,794,714	$ 447,469		$ 393,079	$ (54,390)	$ 8,513,684	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: 10/1/17 Ending: 9/30/18

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		$ 12,794,714	$ 447,469		$ 393,079	$ (54,390)	$ 8,513,684	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
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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)		$ 12,794,714	$ 447,469		$ 393,079	$ (54,390)	$ 8,513,684	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: 10/1/17 Ending: 9/30/18

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	$ 1,903,044	$	$ 26,604	$ 26,604	10	$ 1,760,547	71
72	Current Year Purchases	49,881		3,563	3,563	10	940	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,952,925	$	$ 30,167	$ 30,167		$ 1,761,487	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		Ford Taurus	2000	$ 16,079	$	$	$	4	$ 16,079	76
77		Truck	2003	24,245				4	24,245	77
78		Various		146,608		24,223	24,223	4	136,421	78
79										79
80	TOTALS			$ 186,932	$	$ 24,223	$ 24,223		$ 176,745	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)	$ 14,940,401	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 447,469	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 447,469	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (0)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,451,917	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: 10/1/17 Ending: 9/30/18

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: ____ *

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	$

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: $ 64,915 Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] 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 Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	0.00 hrs	$ 0	0	$ 149,246	$ 0		$ 149,246	1
2	Licensed Speech and Language Development Therapist	V10A	0.00 hrs	0	0	86,441	0		86,441	2
3	Licensed Recreational Therapist	V10A	0.00 hrs	0	0	0	0			3
4	Licensed Physical Therapist	V10A	0.00 hrs	0	0	319,465	0		319,465	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	0.00 hrs	0	0	0	0			8
9	Pharmacy	V39	0.00 # of prescrpts	0	0	0	0			9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39	0.00	0	0	0	0			12
13	Other (specify): BILLABLE SUPPLIES	V39	0.00	0	0	0	7,809		7,809	13
14	TOTAL			$		$ 555,152	$ 7,809		$ 562,961	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/18 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,257	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,384,631)	3,896,246		3
4	Supply Inventory (priced at)			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): See PG17 Support	2,045,589		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,944,092	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	4,072,145		11
12	Long-Term Investments			12
13	Land	5,830		13
14	Buildings, at Historical Cost	4,747,218		14
15	Leasehold Improvements, at Historical Cost	7,486,418		15
16	Equipment, at Historical Cost	2,139,836		16
17	Accumulated Depreciation (book methods)	(10,002,578)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	59,069		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,507,938	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 14,452,030	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,441,660	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	347,451		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,028		33
34	Deferred Compensation	(1,016,894)		34
35	Federal and State Income Taxes	906,014		35
	Other Current Liabilities(specify):			
36				36
37		1,121,967		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,806,226	$	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	Deferred Revenue & Premiums	5,618,625		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,618,625	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,424,851	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,027,179	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 14,452,030	$	48

*(See instructions.)

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,446,932	1
2	Restatements (describe):		2
3	**Equity Adjustment**	639,035	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,085,967	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,058,788)	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)**	$ (1,058,788)	17
	B. Transfers (Itemize):		
18	**ILU net asset activity for the year**		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)**	$ 6,027,179	24 *

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,105,017	1
2	Discounts and Allowances for all Levels	(2,984,951)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,120,066	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		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)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	AL/IL		28
28a	Misc Revenue	3,988,430	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,988,430	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,108,496	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,092,895	31
32	Health Care	7,261,043	32
33	General Administration	4,700,983	33
	B. Capital Expense		
34	Ownership	537,862	34
	C. Ancillary Expense		
35	Special Cost Centers	7,809	35
36	Provider Participation Fee	566,696	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 16,167,284	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,058,788)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,058,788)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,818,274	44
45	Private Pay - Net Inpatient Revenue	801,791	45
46	Medicare - Net Inpatient Revenue	324,625	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	2,160,326	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(2,984,951)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 11,120,065	49

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

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

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

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,147	2,482	$ 141,366	$ 56.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses	37,743	42,835	1,486,063	34.69	3
4	Licensed Practical Nurses	46,814	52,242	1,533,711	29.36	4
5	CNAs & Orderlies	108,459	121,397	1,701,898	14.02	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	16,726	19,053	223,831	11.75	10
11	Social Service Workers	9,300	10,400	167,417	16.10	11
12	Dietician					12
13	Food Service Supervisor	7,407	8,186	145,696	17.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,091	20,295	267,655	13.19	15
16	Dishwashers	30,093	34,251	367,209	10.72	16
17	Maintenance Workers					17
18	Housekeepers	17,394	20,043	244,875	12.22	18
19	Laundry	712	762	15,236	20.00	19
20	Administrator	1,952	2,120	149,406	70.47	20
21	Assistant Administrator	656	1,388	51,867	37.37	21
22	Other Administrative	0	0	0		22
23	Office Manager	1,788	2,085	48,154	23.10	23
24	Clerical	32,961	37,328	711,451	19.06	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	332,242	374,867	$ 7,255,834 *	$ 19.36	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	770	$ 30,696	1	35
36	Medical Director		17,400	9	36
37	Medical Records Consultant	19	1,235	10	37
38	Nurse Consultant				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	55	3,168	11	44
45	Social Service Consultant	15	984	12	45
46	Other(specify)	0	0		46
47		0	0		47
48		0	0		48
49	TOTAL (lines 35 - 48)	859	$ 53,483		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,706	$ 61,691	10	50
51	Licensed Practical Nurses	8,148	311,212	10	51
52	Certified Nurse Assistants/Aides	27,993	677,940	10	52
53	TOTAL (lines 50 - 52)	37,847	$ 1,050,843		53

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Pamela Gentner	Administrator	0	$ 95,187
Monica Plymale	Asst. Admin	0	87,710
Sheila Storey	Administrator	0	82,876
Leonard Koenig	Administrator	0	8,612
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 274,385

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
SAK Management	Management	$ 271,737
Generations	Management	85,458
Marcum LLP	Accounting	8,755
Data Services	Data Services	45,761
Consulting Services	Consulting Services	89,832
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 501,543

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 477,716
Unemployment Compensation Insurance	17,327
FICA Taxes	577,885
Employee Health Insurance	1,952,624
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	670,930
TOTAL (agree to Schedule V, line 22, col.8)	$ 3,696,482

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,793
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues & Subscriptions	9,326
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,119

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	24,413
Seminar Expense	3,745
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 28,158

**See instructions.

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/17 Ending: 9/30/18

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? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **80,773** Line **39**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **No** 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. $ **566,696**
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. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **16,383**

(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? **0**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **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? **Yes**
Firm Name: **Baker Tilly Virchow Krause, LLP**

(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