		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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 (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	GOVERNMENTAL
[ ] 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: Joshua S. Banach   Telephone Number: 847-628-8784
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 10/1/19 to 9/30/20 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)	Denise A Leonard, CPA Partner
	(Firm Name & Address)	Plante & Moran, PLLC 1111 Superior Ave Suite 1250 Cleveland, OH 44114
	(Telephone)	(216) 274-6514 Fax # (248) 233-7349

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: 10/1/19 Ending: 9/30/20

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1	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	732		2,167	2,899	8
9	SNF/PED					9
10	ICF	43,764	5,176	10,235	59,175	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,496	5,176	12,402	62,074	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.79%

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 1,226

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: 9/30/2020 Fiscal Year: 9/30/2020

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	760,158	63,831	37,389	861,378		861,378		861,378			1
2	Food Purchase		702,307		702,307		702,307		702,307			2
3	Housekeeping	271,013	81,270		352,283		352,283		352,283			3
4	Laundry	41,605	456,644		498,249		498,249		498,249			4
5	Heat and Other Utilities			338,057	338,057		338,057	(8,970)	329,087			5
6	Maintenance		426,260		426,260		426,260	(97,347)	328,913			6
7	Other (specify):*			25,787	25,787		25,787		25,787			7
8	**TOTAL General Services**	1,072,776	1,730,312	401,233	3,204,321		3,204,321	(106,317)	3,098,004			8
	B. Health Care and Programs											
9	Medical Director			17,400	17,400		17,400		17,400			9
10	Nursing and Medical Records	3,780,169	556,387	3,430,195	7,766,751		7,766,751		7,766,751			10
10a	Therapy	216,890		540,293	757,183		757,183		757,183			10a
11	Activities	176,006	10,013	2,969	188,988		188,988		188,988			11
12	Social Services	142,548	962	576	144,086		144,086		144,086			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,315,613	567,362	3,991,433	8,874,408		8,874,408		8,874,408			16
	C. General Administration											
17	Administrative	124,881		1,114,000	1,238,881		1,238,881	(856,393)	382,488			17
18	Directors Fees											18
19	Professional Services			550,355	550,355		550,355	114,950	665,305			19
20	Dues, Fees, Subscriptions & Promotions			19,591	19,591		19,591	(14,480)	5,111			20
21	Clerical & General Office Expenses	1,073,700	173,074	1,714,266	2,961,040		2,961,040	(1,681,148)	1,279,892			21
22	Employee Benefits & Payroll Taxes			1,493,593	1,493,593		1,493,593	1,040,159	2,533,752			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,602	3,602		3,602		3,602			24
25	Other Admin. Staff Transportation			7,286	7,286		7,286		7,286			25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	1,198,581	173,074	4,902,693	6,274,348		6,274,348	(1,396,912)	4,877,436			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,586,970	2,470,748	9,295,359	18,353,077		18,353,077	(1,503,229)	16,849,848			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.

River Bluff Nursing Home
0005611
9/30/20
Auto and Travel Expense Detail

Date	General Ledger Accounts	Description of Expense	Employee/Vendor	Employee Function	Final Expense
09/30/20	0401-4-23-705-00-43310	TRAVEL REIMBURSEMENT	ASKEY CARMEN	Various/Admissions	101.09
09/30/20	0401-4-23-705-00-43310	TRAVEL REIMBURSEMENT	LOFGREN MARK	Business Office Manager	97.39
10/31/19	0401-4-23-710-00-43310	TRAVEL	GUSTAFSON LINDSEY	Activities Director	179.42
10/31/19	0401-4-23-740-00-43310	MILEAGE	HUTCHESON SHELLY	Unit Coordinator- Nursing	8.00
10/31/19	0401-4-23-740-00-43310	MILEAGE	HUTCHESON SHELLY	Unit Coordinator- Nursing	5.74
10/31/19	0401-4-23-740-00-43310	TRAVEL	MAYS LINDA	Rehab Department	88.58
11/30/19	0401-4-23-740-00-43310	TRAVEL - MILEAGE	HARRIS THIMOTHY	Administrative Assistant	48.20
12/31/19	0401-4-23-740-00-43310	TRAVEL 12/1/19 - 12/27/19	HARRIS THIMOTHY	Administrative Assistant	35.79
01/31/20	0401-4-23-740-00-43310	TRAVEL	ROGERS DIANE	Various/Admissions	99.01
01/31/20	0401-4-23-740-00-43310	TRAVEL	ROGERS DIANE	Various/Admissions	15.25
01/31/20	0401-4-23-740-00-43310	TRAVEL	ROGERS DIANE	Various/Admissions	48.76
01/31/20	0401-4-23-740-00-43310	TRAVEL	ROGERS DIANE	Various/Admissions	65.15
02/29/20	0401-4-23-740-00-43310	TRAVEL	ROGERS DIANE	Various/Admissions	91.43
02/29/20	0401-4-23-740-00-43310	TRAVEL	ROGERS DIANE	Various/Admissions	14.95
03/31/20	0401-4-23-740-00-43310	TRAVEL	ROGERS DIANE	Various/Admissions	27.37
09/30/20	0401-4-23-740-00-43310	TRAVEL	MCCARTHY BARBARA	Various/Admissions	16.39
10/31/2019	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	645.18
10/31/2019	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	473.40
11/30/2019	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	583.60
12/31/2019	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	468.73
1/31/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	473.47
2/29/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	511.64
3/31/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	381.60
4/30/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	333.06
5/7/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Fleet Services	Various- Facility	71.09
5/28/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Fleet Services	Various- Facility	75.87
5/31/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	408.95
5/31/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	348.47
7/2/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Fleet Services	Various- Facility	49.24
7/23/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Fleet Services	Various- Facility	57.67
7/31/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	317.56
7/31/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	394.08
8/27/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Fleet Services	Various- Facility	50.65
9/24/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Fleet Services	Various- Facility	56.63
9/30/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	111.43
9/30/2020	0401-4-23-745-00-42240	GASOLINE & OIL	Smith Oil Corportation	Various- Facility	531.19
Total					7,286.03

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			393,359	393,359		393,359	163,506	556,865			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			13,912	13,912		13,912		13,912			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,464	1,464		1,464		1,464			35
36	Other (specify):*											36
37	**TOTAL Ownership**			408,735	408,735		408,735	163,506	572,241			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,037		55,037		55,037		55,037			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			537,191	537,191		537,191		537,191			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		55,037	537,191	592,228		592,228		592,228			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,586,970	2,525,785	10,241,285	19,354,040		19,354,040	(1,339,723)	18,014,317			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: 10/1/19 Ending: 9/30/20

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				4
5	Telephone, TV & Radio in Resident Rooms	(8,970)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	163,506	30		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	(1,681,148)	21		24
25	Fund Raising, Advertising and Promotional	(14,480)	20		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	(206,406)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,747,498)		$	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)	407,775		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 407,775		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,339,723)		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

STATE OF ILLINOIS

River Bluff Nursing Home

ID# 0005611

Report Period Beginning: 10/1/19

Ending: 9/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Collections Expense	$ (825)	19	1
2	Website Expenses	(794)	19	2
3	Capitalized R&M	(204,787)	06	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**	(206,406)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
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	(8,970)	0	0	0	0	0	0	0	0	0	0	(8,970)	5
6	Maintenance	(204,787)	0	107,440	0	0	0	0	0	0	0	0	(97,347)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(213,757)	0	107,440	0	0	0	0	0	0	0	0	(106,317)	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	(856,393)	0	0	0	0	0	0	0	0	(856,393)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,619)	0	116,569	0	0	0	0	0	0	0	0	114,950	19
20	Fees, Subscriptions & Promotions	(14,480)	0	0	0	0	0	0	0	0	0	0	(14,480)	20
21	Clerical & General Office Expenses	(1,681,148)	0	0	0	0	0	0	0	0	0	0	(1,681,148)	21
22	Employee Benefits & Payroll Taxes	0	1,040,159	0	0	0	0	0	0	0	0	0	1,040,159	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**	(1,697,247)	1,040,159	(739,824)	0	0	0	0	0	0	0	0	(1,396,912)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,911,004)	1,040,159	(632,384)	0	0	0	0	0	0	0	0	(1,503,229)	29

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	163,506	0	0	0	0	0	0	0	0	0	0	163,506	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**	163,506	0	0	0	0	0	0	0	0	0	0	163,506	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)**	(1,747,498)	1,040,159	(632,384)	0	0	0	0	0	0	0	0	(1,339,723)	45

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

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		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%	$ 447,918	$ 447,918	1
2	V	22	Medicare Payroll Taxes		Winnebago County	100.00%	91,096	91,096	2
3	V	22	FICA Payroll Taxes		Winnebago County	100.00%	385,224	385,224	3
4	V	22	Unemployment Taxes		Winnebago County	100.00%	20,441	20,441	4
5	V	22	Worker's Comp		Winnebago County	100.00%	95,480	95,480	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			$			$ 1,040,159	$ * 1,040,159	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: 10/1/19 Ending: 9/30/20

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		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%	$ 16,663	$ 16,663	15
16	V	06	Bldg/Maint Personnel		Winnebago County	100.00%	107,440	107,440	16
17	V	17	County Board Ofc		Winnebago County	100.00%	51,295	51,295	17
18	V	17	Human Resources		Winnebago County	100.00%	17,731	17,731	18
19	V	17	Purchasing		Winnebago County	100.00%	16,735	16,735	19
20	V	17	County Treasurer		Winnebago County	100.00%	34,301	34,301	20
21	V	17	County Finance		Winnebago County	100.00%	53,647	53,647	21
22	V	19	Audit & Accounting		Winnebago County	100.00%	11,372	11,372	22
23	V	19	Data Processing		Winnebago County	100.00%	105,197	105,197	23
24	V	17	States Atty - Civil		Winnebago County	100.00%	67,235	67,235	24
25	V	17	Administrative Fees	1,114,000	Winnebago County	100.00%		(1,114,000)	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			$ 1,114,000			$ 481,616	$ * (632,384)	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: 10/1/19 Ending: 9/30/20

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 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			$			$	$	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			$			$ 0	$ *	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: 10/1/19 Ending: 9/30/20

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 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			$			$	$	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			$			$ 0	$ *	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: 10/1/19 Ending: 9/30/20

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			$			$ 0	$ *	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: 10/1/19 Ending: 9/30/20

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	N/A		N/A		N/A			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: 10/1/19 Ending: 9/30/20

VII. RELATED PARTIES (continued)

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

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

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

River Bluff Nursing Home
0005611
9/30/2020

Winnebago County Board Members

District 1	Aaron Booker
District 2	Jim Webster
District 3	Steve Schultz
District 4	Brad Lindmark
District 5	Dave Tassoni
District 6	Keith McDonald
District 7	Paul Arena
District 8	John Butitta
District 9	Dave Kelley
District 10	Joe Hoffman
District 11	Kevin McCarthy
District 12	Jamie Salgado
District 13	Angie Goral
District 14	Tim Nabors
District 15	Burt Gerl
District 16	Jean Crosby
District 17	Fred Wescott
District 18	Dorothy Redd
District 19	Angela Fellars
District 20	Jas Bilich

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

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 [ ]

Name of Related Organization: County of Winnebago
Street Address: 404 Elm Street, Room 520
City / State / Zip Code: Rockford, IL 61101
Phone Number: (815) 319-4055
Fax Number: (815) 319-4051

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

	1 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	17,319,407	11	$ 447,918	$	17,319,407	$ 447,918	1
2	22	Medicare Payroll Taxes	Direct Cost	17,319,407	11	91,096		17,319,407	91,096	2
3	22	FICA Payroll Taxes	Direct Cost	17,319,407	11	385,224		17,319,407	385,224	3
4	22	Unemployment Taxes	Direct Cost	17,319,407	11	20,441		17,319,407	20,441	4
5	22	Worker's Comp	Direct Cost	17,319,407	11	95,480		17,319,407	95,480	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					$ 1,040,159	$		$ 1,040,159	25

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	17	County Auditor	Operating Expense	196,472,514	11	$ 189,024	$ 185,348	17,319,407	$ 16,663	1
2	06	Bldg/Maint Personnel	Operating Expense	196,472,514	11	1,218,809	1,218,138	17,319,407	107,440	2
3	17	County Board Ofc	Operating Expense	196,472,514	11	581,897	421,861	17,319,407	51,295	3
4	17	Human Resources	Operating Expense	196,472,514	11	201,137	184,061	17,319,407	17,731	4
5	17	Purchasing	Operating Expense	196,472,514	11	189,839	175,500	17,319,407	16,735	5
6	17	County Treasurer	Operating Expense	196,472,514	11	389,117	270,979	17,319,407	34,301	6
7	17	County Finance	Operating Expense	196,472,514	11	608,572	264,948	17,319,407	53,647	7
8	19	Audit & Accounting	Operating Expense	196,472,514	11	129,000		17,319,407	11,372	8
9	19	Data Processing	Operating Expense	196,472,514	11	1,193,366	830,031	17,319,407	105,197	9
10	17	States Atty - Civil	Operating Expense	196,472,514	11	762,718	749,523	17,319,407	67,235	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					$ 5,463,479	$ 4,300,389		$ 481,616	25

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 10/1/19 Ending: 9/30/20

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 10/1/19 Ending: 9/30/20

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 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						$	$		$	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: 10/1/19 Ending: 9/30/20

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			$	$			$ 13,912	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 13,912	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 13,912	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: 10/1/19 Ending: 9/30/20

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2019 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 2020 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:		
2015		8
2016		9
2017		10
2018		11
2019		12

Not Applicable to the Facility

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	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.**

2019 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 Joshua S. Banach

TELEPHONE 847-628-8784 FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2019 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 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A	N/A	$ N/A	$ N/A
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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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-Combust. 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).
None

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	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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	$		$	$	$ 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			19,029	30
31	Various			1999	48,763		20			48,763	31
32	Various			2000	88,615		20			88,615	32
33	Various			2001	113,136		20			113,136	33
34	Various			2002	379,998		20	19,000	19,000	360,998	34
35	Various			2003	300,474		20	15,024	15,024	270,427	35
36	Various			2004	1,617,574		20	80,879	80,879	1,374,938	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: 10/1/19 Ending: 9/30/20

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	$ 64,895	37
38	Various	2006	272,911		20	13,646	13,646	204,683	38
39	Various	2007	136,310		20	6,816	6,816	95,417	39
40	Various	2008	56,319		20	2,816	2,816	36,607	40
41	Various	2009	46,742		20	2,337	2,337	28,045	41
42	Various	2010	665,059		20	33,253	33,253	365,782	42
43	Various	2011	77,034		20	3,852	3,852	38,517	43
44	Various	2012	197,175		20	9,859	9,859	88,729	44
45	Various	2013	147,442		20	7,372	7,372	58,977	45
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63									63
64									64
65									65
66									66
67									67
68									68
69	Financial Statement Depreciation			393,359			(393,359)		69
70	TOTAL (lines 4 thru 69)		$ 9,138,190	$ 393,359		$ 198,908	$ (194,451)	$ 8,148,049	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: 10/1/19 Ending: 9/30/20

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	$ 393,359		$ 198,908	$ (194,451)	$ 8,148,049	1
2	Sprinkler System	2014	3,025,124		20	151,256	151,256	1,058,793	2
3	Cooling Coil Replacement	2014	13,990		20	700	700	4,897	3
4	Heating Valve Replacement	2014	13,850		20	693	693	4,848	4
5	Heating Coil Replacement	2014	16,400		20	820	820	5,740	5
6	Oxygen Storage Pipe	2014	13,260		20	663	663	4,641	6
7	Air System Compressor	2014	24,680		20	1,234	1,234	8,638	7
8	New Carpet Tile For The Facility Entrance Way	2014	5,050		20	253	253	1,768	8
9	Repaired/Replaced 15 Damper Assemblies	2014	4,165		20	208	208	1,458	9
10	Air Handler Unit #3, D Wing- Repairs	2014	14,273		20	714	714	4,996	10
11	New Chiller	2014	4,308		20	215	215	1,508	11
12	Gravel For Landscaping	2014	13,125		20	656	656	4,594	12
13	Repair Cooling System- Air Handler Not Functioning	2014	24,680		20	1,234	1,234	8,638	13
14	Fire Damper Repairs	2014	14,965		20	748	748	5,238	14
15	New Water Heater	2014	8,308		20	415	415	2,908	15
16	Replaced Heating Coil In Air Handler #2	2014	16,400		20	820	820	5,740	16
17	Removed And Repaired Cooling Coil	2014	11,270		20	564	564	3,945	17
18	Replaced Oxygen Storage Piping	2014	13,260		20	663	663	4,641	18
19	Supply & Install Interior Logo, Illuminated Single Sided Sign	2015	14,280		20	714	714	4,284	19
20	Replaced Compressor	2015	9,875		20	494	494	2,963	20
21	Installed,Piped, And Wired Dish Sink Disposal	2015	7,907		20	395	395	2,372	21
22	Install New Bullhorns/Tenons/Ballast On 2-North Parking Lot Lig	2015	2,855		20	143	143	857	22
23	Design/Fabricate Registers For Dining/Patient Rooms. Install New	2015	5,285		20	264	264	1,586	23
24	Ups System Pathway Lights/Neighborhood Em Lights	2016	11,200		20	560	560	2,800	24
25	Generator Repair	2016	153,800		20	7,690	7,690	38,450	25
26	Overhaul Trane Centrifugal Chiller & Bearings	2016	51,235		20	2,562	2,562	12,809	26
27	Provide & Install New Heating Coil In Maintenance Area	2016	4,238		20	212	212	1,060	27
28	Circulating Taco Pump Bldg. A	2016	7,182		20	359	359	1,796	28
29	Repipe Under Sink Lines, Install Mixing Valves/New Faucet	2016	3,854		20	193	193	964	29
30	Bonnet/Valve/Dial Repair	2016	4,537		20	227	227	1,134	30
31	Check/Install New Garbage Disposal	2016	3,381		20	169	169	845	31
32	New Chiller Motor	2016	9,385		20	469	469	2,346	32
33	Replace,Program,Startup, And Commission Cooling Tower Frequ	2016	4,741		20	237	237	1,185	33
34	TOTAL (lines 1 thru 33)		$ 12,669,053	$ 393,359		$ 375,451	$ (17,908)	$ 9,356,485	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: 10/1/19 Ending: 9/30/20

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 12B, Carried Forward		$ 12,669,053	$ 393,359		$ 375,451	$ (17,908)	$ 9,356,485	1
2	Installation Of Tank	2016	6,724		20	336	336	1,681	2
3	Electrical Repairs	2016	6,040		20	302	302	1,510	3
4	Magnaflux, Pressure Test & Resurface Cylinder Heads	2016	6,095		20	305	305	1,524	4
5	Change Hot Water Cir Pump In C-Wing	2016	2,903		20	145	145	726	5
6	Swap Out Gas And Diesel Pump	2017	2,500		20	125	125	500	6
7	Replace 7 Fire Damper Actuators	2017	4,525		20	226	226	905	7
8	Boiler Repair - Replace Gas Valve Body And Actuator	2017	4,980		20	249	249	996	8
9	Plumbing Work - Install Pump In E-Wing Pump #2	2017	2,936		20	147	147	587	9
10	Change Hot Water Cir Pump In D-Wing	2017	2,936		20	147	147	587	10
11	Excavation And Blacktop - Asphalt Paving	2017	4,672		20	234	234	934	11
12	Replace Dishroom Door	2017	6,609		20	330	330	1,322	12
13	B-2/B-4 Shower Rooms - Patch/Caulk Wall & Floor Tile, Install Co	2017	4,374		20	219	219	875	13
14	Shower Rooms C-2,C-4,D-2,D-4 - Remove Framing, Plywood, Tile	2017	6,196		20	310	310	1,239	14
15	Install Additional Door In Basement	2017	3,309		20	165	165	662	15
16	Installation Of 3 Fixed Dome/360 Degree Cameras On Patio	2017	10,982		20	549	549	2,196	16
17	Blast Chiller	2018	26,153		20	1,308	1,308	3,923	17
18	Steamer-Convection	2018	23,727		20	1,186	1,186	3,559	18
19	Fabricate/Install Corner Guards:#1 Hall & Main Dining Area	2019	8,220		20	411	411	822	19
20	Replacement of Boiler Back Flow Device	2019	2,972		20	149	149	297	20
21	Replacement of Grease Trap- Kitchen	2019	4,980		20	249	249	498	21
22	Repair to Chiller-Dynaview Screen and Configuration	2019	3,312		20	166	166	331	22
23	Cabling for Low Voltage Sensors & Transductors for Chiller	2019	5,990		20	300	300	599	23
24	Repair to Tower Bypass Valve/Condensor for Chiller	2019	2,624		20	131	131	262	24
25	Replacement Coils on the HVAC systems	2019	4,200		20	210	210	420	25
26	Replacement Pneumatic Actuators and Relays on Dampers	2019	3,429		20	171	171	343	26
27	Replacement Coils on the HVAC systems	2019	9,400		20	470	470	940	27
28	Piping Water Softener to Steamer and Insultated Piping	2019	3,400		20	170	170	340	28
29	Replacement Inlet Guide- Vane Actuator- Chiller	2019	5,867		20	293	293	587	29
30	Chiller Repairs- Sensors, Transductors, Valves, Condensors	2019	3,956		20	198	198	396	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,853,064	$ 393,359		$ 384,652	$ (8,707)	$ 9,386,047	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: 10/1/19 Ending: 9/30/20

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		$ 12,853,064	$ 393,359		$ 384,652	$ (8,707)	$ 9,386,047	1
2	Current Fiscal Year Additions								2
3	Repairs to Tunnels in B/C/D/E Wings- Piping and Enclosures	2019	14,124		20	706	706	706	3
4	Mold Remediation in Basement/Supply Room Plus Conduit	2019	8,580		20	429	429	429	4
5	Drywall/Ceiling/Tiling Repairs in Kitchen Area	2019	8,300		20	415	415	415	5
6	Drywall/Ceiling/Tiling Repairs in 2 Front Kitchen Areas	2019	7,700		20	385	385	385	6
7	Repairs To Lighting & Electrical in Kitchen	2019	7,000		20	350	350	350	7
8	Drywall/Ceiling/Tiling Repairs in Storage Room	2019	6,372		20	319	319	319	8
9	Repairs To Lighting & Electrical in Kitchen	2019	6,000		20	300	300	300	9
10	Replace Piping Under Kitchen	2019	4,714		20	236	236	236	10
11	Replace Sight Glass on Steam Boiler/Heat Exchanger	2019	3,905		20	195	195	195	11
12	Boiler & Cooling Water Treatment/Red Indicator System	2019	3,719		20	186	186	186	12
13	Hot Water Boiler- Repiping and Vent valves	2019	3,519		20	176	176	176	13
14	Repairs To Lighting & Electrical in Kitchen	2019	3,500		20	175	175	175	14
15	Boiler Repair- Damper Shaft & Actuators	2020	3,229		20	161	161	161	15
16	15 Gallon Water Treatment/Cooling System	2020	2,727		20	136	136	136	16
17	C Wing AC Syst Repair-Selector Switch & Receiver/Controller	2020	2,604		20	130	130	130	17
18	Repairs To Lighting & Electrical in Kitchen	2020	2,500		20	125	125	125	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	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: 10/1/19 Ending: 9/30/20

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		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	1
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4									4
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	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: 10/1/19 Ending: 9/30/20

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 12E, Carried Forward		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	1
2									2
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4									4
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	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: 10/1/19 Ending: 9/30/20

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		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	1
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4									4
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	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: 10/1/19 Ending: 9/30/20

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 12G, Carried Forward		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	1
2									2
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4									4
5									5
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	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: 10/1/19 Ending: 9/30/20

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		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	1
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4									4
5									5
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,941,557	$ 393,359		$ 389,076	$ (4,283)	$ 9,390,471	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: 10/1/19 Ending: 9/30/20

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	$ 1,485,077	$	$ 148,508	$ 148,508	10	$ 1,485,077	71
72	Current Year Purchases	116,294		11,629	11,629	10	11,629	72
73	Fully Depreciated Assets	496,267				10	496,267	73
74								74
75	TOTALS	$ 2,097,638	$	$ 160,137	$ 160,137		$ 1,992,973	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	Facility	Ford Taurus	2000	$ 16,079	$	$	$	4	$ 16,079	76
77	Facility	Ford Super Duty F-250	2019	30,607		7,652	7,652	4	7,652	77
78	Facility	Various	Various	146,608				4	146,608	78
79										79
80	TOTALS			$ 193,294	$	$ 7,652	$ 7,652		$ 170,339	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)	$ 15,238,319	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 393,359	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 556,865	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 163,506	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 11,553,783	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: 10/1/19 Ending: 9/30/20

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.	/2021	$
13.	/2022	$
14.	/2023	$

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: $ 1,464 Description: $1,464 Postage Meter
(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: 10/1/19 Ending: 9/30/20

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.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	V10A	hrs	$	1,999	$ 139,901	$	1,999	$ 139,901	1
2	Licensed Speech and Language Development Therapist	V10A	hrs		1,455	101,839		1,455	101,839	2
3	Licensed Recreational Therapist	V10A	hrs							3
4	Licensed Physical Therapist	V10A	hrs		4,265	298,553		4,265	298,553	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation	V39	hrs	216,890					216,890	8
9	Pharmacy	V39	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LAB/RADIOLOGY	V39								12
13	Other (specify): BILLABLE SUPPLIES	V39					55,037		55,037	13
14	TOTAL			$ 216,890	7,718	$ 540,293	$ 55,037	7,718	$ 812,220	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.

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/20 (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	$ 262	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 3,707,638)	8,577,802		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 Attached	3,204,172		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 11,782,236	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	4,312,397		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	2,146,198		16
17	Accumulated Depreciation (book methods)	(10,787,412)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	55,873		21
22	Other Long-Term Assets (spe See Attached			22
23	Other(specify): See Attached			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,966,522	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 19,748,758	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,407,431	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	394,842		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	3,103		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	974,633		35
	Other Current Liabilities(specify):			
36	See Attached			36
37	See Attached	1,185,797		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,965,806	$	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	See Attached	3,834,324		43
44	See Attached			44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,834,324	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,800,130	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,948,628	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 19,748,758	$	48

*(See instructions.)

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PG 17 Line 9 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
1070.10	00000-11110	REAL ESTATE TAX RECEIVABLE	1,993,025.47
1090.60	00000-13100	SUPPLIES	100,619.39
2050.5	00000-21906	NET PENSION OBLIGATION	1,110,527.00
Total			3,204,171.86

PG 17 Line 22 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
Total			-

PG 17 Line 23 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
Total			-

PG 17 Line 36 Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
Total			-

PG 17 Line 37 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
2060.60	00000-21902	POSTEMPLOYMENT INS. LIABILITY	(772,492.90)
2090.30	00000-22244	2012 A GO Riverr Bluff Nursing	(413,303.92)
Total			(1,185,796.82)

PG 17 Line 43 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
2450.40	00000-26502	DEFERRED PREMIUM & DISCOUNTS O	(16,348.45)
2450.10	00000-27100	DEF PROPERTY TAX	(1,905,790.53)
2450.40	00000-26512	DEF. INFLOW EXP / ACT EXPERIEN	(1,900,759.00)
2450.40	00000-26520	DEFERRED INFLOW-OPEB	(11,426.00)
Total			(3,834,323.98)

PG 17 Line 44 Detail

MCD ACT	CLIENT_ACT	DESC	DEBIT
Total			-

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,518,765	1
2	Restatements (describe):		2
3	**Adjustments to Appropriations, Budgetary Balance,**	6,786,363	3
4	**and Revenues from County**		4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 14,305,128	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,356,500)	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)**	$ (2,356,500)	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)**	$ 11,948,628	24 *

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

Facility Name & ID Number River Bluff Nursing Home # 0005611 Report Period Beginning: 10/1/19 Ending: 9/30/20

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	$ 12,951,387	1
2	Discounts and Allowances for all Levels	(2,115,799)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,835,588	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,548,150	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,548,150	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			28
28a		4,613,802	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,613,802	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 16,997,540	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	3,204,321	31
32	Health Care	8,874,408	32
33	General Administration	6,274,348	33
	B. Capital Expense		
34	Ownership	408,735	34
	C. Ancillary Expense		
35	Special Cost Centers	55,037	35
36	Provider Participation Fee	537,191	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 19,354,040	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,356,500)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,356,500)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 9,069,202	44
45	Private Pay - Net Inpatient Revenue	213,490	45
46	Medicare - Net Inpatient Revenue	255,305	46
47	Other-(specify) ALL OTHER SNF/SCF IP REVENUE	3,413,390	47
48	Other-(specify) C/A ANCILLARY ACCOUNTS	(2,115,799)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,835,588	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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.

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PG 19 Line 28A Detail

MCD ACT	CLIENT_ACT	DESC	BALANCE
5750	70500-31110	REAL ESTATE TAXES	(1,828,086.90)
5750	70500-31111	TIF SURPLUS MACHESNEY PARK	(3,310.11)
5750	70500-31120	BACK TAXES	(837.07)
5750	70500-31130	MOBILE HOME TAXES	(1,278.59)
5750	70500-31610	GENERAL PROPERTY	(4,194.54)
5750	70500-32243	RBNH-FEDERAL MATCHING	(1,279,039.93)
5750	70500-39990	OTHER UNCLASSIFIED REVENUE- COVID STIMULUS	(1,485,001.69)
5750	70500-45115	AMORTIZATION OF PREM ON BONDS	(10,898.97)
5750	70500-39990	OTHER UNCLASSIFIED REVENUE- MEDICAL RECORDS	(1,153.75)
Total			**(4,613,801.55)**

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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	1,594	1,974	$ 96,230	$ 48.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,941	33,150	1,226,100	36.99	3
4	Licensed Practical Nurses	41,960	47,282	1,482,406	31.35	4
5	CNAs & Orderlies	50,291	57,710	975,433	16.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,154	9,338	216,890	23.23	8
9	Activity Director	1,962	2,088	43,782	20.97	9
10	Activity Assistants	10,052	11,321	132,224	11.68	10
11	Social Service Workers	5,289	8,193	142,548	17.40	11
12	Dietician					12
13	Food Service Supervisor	6,752	7,949	153,658	19.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	7,672	9,949	142,254	14.30	15
16	Dishwashers	35,780	40,022	464,245	11.60	16
17	Maintenance Workers					17
18	Housekeepers	20,468	23,478	271,013	11.54	18
19	Laundry	1,370	1,708	41,605	24.36	19
20	Administrator	1,690	2,026	124,881	61.64	20
21	Assistant Administrator					21
22	Other Administrative	1,829	2,082	66,285	31.84	22
23	Office Manager	2,854	3,350	82,166	24.53	23
24	Clerical	55,496	63,591	925,249	14.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	284,154	325,211	$ 6,586,969 *	$ 20.25	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	713	$ 37,389	V01-03	35
36	Medical Director	Monthly	17,400	V09-03	36
37	Medical Records Consultant				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	43	2,981	V11-03	44
45	Social Service Consultant	8	576	V12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	764	$ 58,346		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	5,331	$ 262,204	V10-03	50
51	Licensed Practical Nurses	9,987	472,030	V10-03	51
52	Certified Nurse Assistants/Aides	74,365	2,668,905	V10-03	52
53	TOTAL (lines 50 - 52)	89,682	$ 3,403,139		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia McDiarmid	Administrator	0.00%	$ 124,881
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 124,881

B. Administrative - Other

Description	Amount
Winnebago County- Administrative Support	$ 1,114,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,114,000

C. Professional Services

Vendor/Payee	Type	Amount
Generations Health Network	Management	$ 484,030
Plante Moran	Accounting Services	7,500
Markoff Law LLC	Legal (Adjusted)	825
Point Click Care	Data Processing/Software	43,252
Sage Software	Data Processing/Software	1,854
GoDaddy	Website (Adjusted)	64
Jumping Trout	Website (Adjusted)	730
Meal Suite	Meal Management Software	2,556
Pathways	Healthcare Consulting	5,041
Nexstar Digital	Digital Consulting Services	4,503
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 550,355

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,480
Unemployment Compensation Insurance	20,441
FICA Taxes	476,320
Employee Health Insurance	1,431,657
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	447,918
Pension Expense	22,736
Life Insurance	3,378
Other Employee Benefits	35,822
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,533,752

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	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	66
(Indicate # of checks performed 3)	
Patient Background Checks	
Dues & Memberships	970
Licenses & Fees	2,085
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,111

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,602
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,602

**See instructions.

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9/30/20
Detail of Legal Expense

Date	General Ledger Accounts	Vendor	Description of Expense	Invoice Expense	Adjustments& Reclassifications	Final Expense
9/30/2020	0401-4-23-705-00-43140	Markoff Law LLC	Collections (Adjusted)	825.00	(825.00)	-
Total						

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. $ **74,155** Line **39**

(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. $ **537,191**
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. $ **7,557**

(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? **N/A**
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**

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.