FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0000786

Facility Name: VERMILION MANOR NURSING HOME

Address: 14792 CATLIN-TILTON ROAD (Number) DANVILLE (City) 61834 (Zip Code)

County: VERMILION

Telephone Number: 217-443-6430 **Fax #** 217-443-1558

HFS ID Number:

Date of Initial License for Current Owners: 01/01/1974

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: JOAN DARR **Telephone Number:** 217-443-6430
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 12/1/09 to 11/30/10 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) JOAN DARR
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (Date)
(Print Name and Title) SEE ATTACHED ACCOUNTANT'S REPORT
(Firm Name & Address) CLIFTON GUNDERSON LLP
2 E MAIN STREET, SUITE 120, DANVILLE, IL 61832
(Telephone) 217-442-1643 Fax # 217-443-5470

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 VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	142	Skilled (SNF)	142	51,922	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	34,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	237	86,692	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	4,546	378	8,409	13,333	8
9	SNF/PED					9
10	ICF	34,520	7,904	342	42,766	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,066	8,282	8,751	56,099	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.71%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? 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 1/1/1974

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 92 and days of care provided 6,517

Medicare Intermediary _____

IV. ACCOUNTING BASIS

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

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

Tax Year: N/A Fiscal Year: 12/1/09-11/30/10

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	570,783	49,717	61,528	682,028		682,028		682,028			1
2	Food Purchase		416,208		416,208		416,208		416,208			2
3	Housekeeping	181,639	31,800		213,439		213,439		213,439			3
4	Laundry	110,702	19,909		130,611		130,611		130,611			4
5	Heat and Other Utilities			164,172	164,172	(300)	163,872	(14,381)	149,491			5
6	Maintenance	153,129	38,371	75,918	267,418		267,418		267,418			6
7	Other (specify):* WASTE DISPOSAL			34,592	34,592		34,592		34,592			7
8	TOTAL General Services	1,016,253	556,005	336,210	1,908,468	(300)	1,908,168	(14,381)	1,893,787			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000	(24,000)						9
10	Nursing and Medical Records	3,520,371	805,460	90,768	4,416,599		4,416,599		4,416,599			10
10a	Therapy			805,866	805,866		805,866		805,866			10a
11	Activities	82,309		1,792	84,101		84,101		84,101			11
12	Social Services	124,388		5,836	130,224		130,224		130,224			12
13	CNA Training											13
14	Program Transportation			120	120		120		120			14
15	Other (specify):* PLAN COORDINAT	114,256			114,256		114,256		114,256			15
16	TOTAL Health Care and Programs	3,841,324	805,460	928,382	5,575,166	(24,000)	5,551,166		5,551,166			16
	C. General Administration											
17	Administrative	78,251			78,251		78,251		78,251			17
18	Directors Fees											18
19	Professional Services			2,450	2,450		2,450		2,450			19
20	Dues, Fees, Subscriptions & Promotions			38,040	38,040		38,040		38,040			20
21	Clerical & General Office Expenses	177,949	34,068	102,687	314,704		314,704		314,704			21
22	Employee Benefits & Payroll Taxes			1,197,560	1,197,560		1,197,560		1,197,560			22
23	Inservice Training & Education			2,310	2,310		2,310		2,310			23
24	Travel and Seminar			622	622		622		622			24
25	Other Admin. Staff Transportation			9,931	9,931		9,931		9,931			25
26	Insurance-Prop.Liab.Malpractice			59,959	59,959		59,959		59,959			26
27	Other (specify):*											27
28	TOTAL General Administration	256,200	34,068	1,413,559	1,703,827		1,703,827		1,703,827			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,113,777	1,395,533	2,678,151	9,187,461	(24,300)	9,163,161	(14,381)	9,148,780			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 VERMILION MANOR NURSING HOME #0000786 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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			201,203	201,203		201,203		201,203			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			454	454		454		454			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			201,657	201,657		201,657		201,657			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					24,000	24,000		24,000			39
40	Barber and Beauty Shops					300	300		300			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,806	129,806		129,806		129,806			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			129,806	129,806	24,300	154,106		154,106			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,113,777	1,395,533	3,009,614	9,518,924		9,518,924	(14,381)	9,504,543			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 VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	(14,381)	V5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (14,381)		$	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)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (14,381)		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			300	V5(3)	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)**			$ 300		47

VERMILION MANOR NURSING HOME

ID# 0000786

Report Period Beginning: 12/1/09

Ending: 11/30/10

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	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**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

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

	Capital Expense D. Ownership	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)	
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)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A		N/A		VERMILION COUNTY	DANVILLE	COUNTY GOVERNMENT

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)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								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			$			$	$ *	14

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	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 Reference	
						Hours	Percent	Description	Amount		
1	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								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 VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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 [X]

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 VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	OPERATING LOAN FROM						$	$			$	1
2	VERMILION COUNTY											2
3	GENERAL FUND	X		OPERATING CASH FLOW	$26,038.00	2/15/07	888,593		2/15/10	3.5000	454	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$26,038.00		$ 888,593	$			$ 454	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 888,593	$			$ 454	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

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

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	N/A	2
3. Under or (over) accrual (line 2 minus line 1).	$	N/A	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	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.)	$	N/A	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.)	$	N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	N/A	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	N/A	8
2006	N/A	9
2007	N/A	10
2008	N/A	11
2009	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME VERMILION MANOR NURSING HOME COUNTY VERMILION

FACILITY IDPH LICENSE NUMBER 0000786

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE ( ) _____ FAX #: ( ) _____

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

Enter the tax index number and real estate tax assessed for 2009 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 2009.

	(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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,800 B. General Construction Type: Exterior BRICK Frame SINGLE STORY Number of Stories ONE

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. [ ] (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	INFORMATION NOT AVAILABLE			$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	142		1974	1974	$ 2,290,108	$ 57,253	40	$ 57,253	$	$ 2,108,797	4
5	95		1979	1979	1,961,500	49,038	40	49,038		1,539,988	5
6											6
7											7
8											8
	Improvement Type**										
9	PARKING LOT/GARAGE			1980	16,200		10			16,200	9
10	CONSTRUCTION			1980	92,111	2,303	40	2,303		71,389	10
11	FINAL CONSTRUCTION			1981	6,000	150	40	150		4,500	11
12	PUMP			1982	9,414		10			9,414	12
13	ROOF			1982	40,042		10			40,042	13
14	ROOF			1983	39,569		10			39,569	14
15	ROOF			1984	52,663		10			52,663	15
16	WATER HEATER			1985	27,463		10			27,463	16
17	WATER LINE			1985	5,290		10			5,290	17
18	DRIVEWAY			1985	4,200		10			4,200	18
19	LINT CATCHER			1986	5,981		10			5,981	19
20	PARKING LOT/GARAGE			1986	26,927		10			26,927	20
21	ROOF/DUCT WORK			1986	6,114		10			6,114	21
22	FENCE			1986	609		10			609	22
23	400 AMP LINE			1988	3,400		20			3,400	23
24	PVC RUB RAILS			1988	2,821		20			2,821	24
25	CANOPY REPAIRS			1988	12,075		20			12,075	25
26	REPLATE CERAMIC TILE			1988	2,485		20			2,485	26
27	TIME CLOCK/COMPUTER			1988	2,030		20			2,030	27
28	REPAIR CERAMIC TILE			1988	4,387		20			4,387	28
29	CONDITIONER			1988	17,116		15			17,116	29
30	WATER METER			1988	1,457		20			1,457	30
31	BUILDING IMPROVEMENTS			1989	334		20			334	31
32	DOOR O MATIC			1989	1,763		20			1,763	32
33	AIR CONDITIONERS			1990	146,034	3,923	20	3,923		146,034	33
34	FIRE RATED DOOR			1990	358	1	20	1		358	34
35	BUILDING IMPROVEMENTS			1990	163	1	20	1		163	35
36	WINDOW			1990	198	2	20	2		198	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 VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	AIR CONDITIONER UNIT	1990	$ 14,149	$ 236	20	$ 236	$	$ 14,149	37
38	CAPITAL IMPROVEMENTS	1990	18,139	227	20	227		18,139	38
39	HOT WATER STORAGE TANK	1990	4,589	76	20	76		4,589	39
40	AIR CONDITIONER UNITS	1990	6,602	193	20	193		6,602	40
41	ROOF REPAIR	1991	10,500	525	20	525		10,413	41
42	FIRE HYDRANT	1991	2,185	109	20	109		2,167	42
43	PUMPS	1991	1,700	85	20	85		1,679	43
44	AIR CONDITIONERS	1991	9,217	461	20	461		8,948	44
45	LOCK ON SERVICE DOORS	1991	55	3	20	3		53	45
46	CAPITAL IMPROVEMENTS	1991	1,370	68	20	68		1,313	46
47	FIRE DOOR AND SENSORS	1991	1,586	79	20	79		1,520	47
48	SHEETROCK AND BUILDING MATERIALS	1991	143	7	20	7		137	48
49	SIGNS	1991	122	6	20	6		116	49
50	LIGHT FIXTURES	1991	180	9	20	9		172	50
51	CAPITAL IMPROVEMENTS	1991	899	45	20	45		858	51
52	PLUMBING	1991	7,162	358	20	358		6,833	52
53	CORNER GUARDS	1991	367	18	20	18		350	53
54	AIR HANDLER	1991	3,661	183	20	183		3,478	54
55	CAPITAL IMPROVEMENTS	1992	4,880	244	20	244		4,595	55
56	GENERATOR	1992	19,380	969	20	969		18,169	56
57	PLUMBING	1992	11,543	577	20	577		10,822	57
58	PLUMBING	1992	21,222	1,061	20	1,061		19,807	58
59	GENERATOR	1992	46,548	2,327	20	2,327		43,251	59
60	PLUMBING	1992	21,293	1,065	20	1,065		19,785	60
61	CAPITAL IMPROVEMENTS	1992	11,616	581	20	581		10,793	61
62	LIGHT FIXTURES	1992	1,395	70	20	70		1,290	62
63	PLUMBING	1992	8,826	441	20	441		8,164	63
64	AIR CONDITIONER	1992	2,765	138	20	138		2,523	64
65	AIR CONDITIONER	1992	5,368	268	20	268		4,898	65
66	CAPITAL IMPROVEMENTS	1992	4,452	223	20	223		4,025	66
67	REROOFING	1993	4,000	200	20	200		3,550	67
68	WALK IN FREEZER	1993	11,400	570	20	570		10,070	68
69	CALL MASTER STATION	1993	3,215		15			3,215	69
70	TOTAL (lines 4 thru 69)		$ 5,039,341	$ 124,093		$ 124,093	$	$ 4,400,240	70

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 5,039,341	$ 124,093		$ 124,093	$	$ 4,400,240	1
2	CAPITAL IMPROVEMENTS	1993	4,968	248		248		4,347	2
3	ROOFING	1993	32,207	1,610		1,610		28,047	3
4	ROOFING	1993	2,775	139		139		2,417	4
5	SMOKING ROOM	1993	6,511	326		326		5,670	5
6	A LOUNGE WALL	1993	1,004	50		50		866	6
7	KITCHEN	1993	4,984	249		249		4,257	7
8	HOT WATER HEATER	1994	5,987	299		299		4,989	8
9	ACTIVATOR	1994	1,190	59		59		991	9
10	LABOT DAMPERS	1994	3,082	154		154		2,530	10
11	CALL SYSTEM	1994	3,427	171		171		2,742	11
12	GARAGE	1994	4,050	203		203		3,240	12
13	ROOFING	1994	38,981	1,949		1,949		31,185	13
14	DOOR OPENER	1994	2,849	142		142		2,279	14
15	CAPITAL IMPROVEMENTS	1994	4,952	248		248		3,961	15
16	GARAGE	1994	1,403	70		70		1,122	16
17	BOOSTER HEATER	1994	4,320					4,320	17
18	CALL LIGHT SYSTEM	1995	3,577					3,577	18
19	FOLDING PARTITION	1995	4,880					4,880	19
20	REWIRE GARAGE	1995	650	33		33		488	20
21	EXHAUST SYSTEM	1995	5,346					5,346	21
22	FRONT ENTRANCE	1996	1,050	70		70		1,009	22
23	DRIVEWAY	1996	10,170	678		678		9,718	23
24	CANOPY	1996	19,619	1,308		1,308		18,529	24
25	TILE REPLACEMENT	1996	1,129					1,129	25
26	ROOF REPAIR	1996	30,645	1,532		1,532		20,558	26
27	REPAIR DRIVE	1997	2,900					2,900	27
28	AIR CONDITIONER UNITS	1997	15,322	766		766		10,151	28
29	WATER HEATER	1998	6,200					6,200	29
30	ROOF	1998	21,809					21,809	30
31	AIR CONDITIONER UNITS	1998	9,160	458		458		5,534	31
32	CAPITAL IMPROVEMENTS	1998	1,012					1,012	32
33	AIR CONDITIONER UNITS	1998	8,580	429		429		5,148	33
34	TOTAL (lines 1 thru 33)		$ 5,304,080	$ 135,284		$ 135,284	$	$ 4,621,191	34

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		$ 5,304,080	$ 135,284		$ 135,284	$	$ 4,621,191	1
2	AIR CONDITIONER UNITS		49,921	2,496		2,496		28,289	2
3	ROOF		22,973	1,149		1,149		13,018	3
4	CANOPY REPAIR		7,630	382		382		4,292	4
5	GENERATOR		7,951	398		398		4,208	5
6	WATER HEATER		8,368	418		418		4,323	6
7	CONDENSER		2,350	118		118		1,204	7
8	CANOPY REPAIR		7,700	513		513		5,048	8
9	HOT WATER HEATER		1,634	164		164		1,566	9
10	ELECTRIC BOOSTER HEATER		1,639	164		164		1,542	10
11	BOILER REPAIR		23,800	1,587		1,587		14,544	11
12	AIR CONDITIONER UNITS		8,367	418		418		3,347	12
13	LIGHTING RENOVATIONS		8,402	420		420		3,361	13
14	PARKING LOT IMPROVEMENTS		4,800	320		320		2,320	14
15	BOILERS		2,529	169		169		1,166	15
16	CARPETING		1,564	156		156		938	16
17	WATER HEATER		4,807	481		481		2,885	17
18	SPRINKLER SYSTEM		103,956	10,396		10,396		62,374	18
19	COMMINUTOR		11,338	850		850		850	19
20	EXHAUST FAN		5,350	89		89		89	20
21	FIRE ALARM		25,800	430		430		430	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)		$ 5,614,959	$ 156,402		$ 156,402	$	$ 4,776,985	34

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 778,209	$ 28,650	$ 28,650	$	VARIOUS	$ 728,551	71
72	Current Year Purchases	52,045	5,344	5,344		VARIOUS	5,344	72
73	Fully Depreciated Assets	405,741					405,741	73
74								74
75	TOTALS	$ 1,235,995	$ 33,994	$ 33,994	$		$ 1,139,636	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	FORD VAN 1996	1996	$ 22,296	$	$	$		$ 22,296	76
77	RESIDENT TRANSPORT	CHEVY VAN W/LIFTS 2002	2002	24,602					24,602	77
78	MAINTENANCE	FORD TRUCK 2009	2009	24,814	4,963	4,963			8,685	78
79	RESIDENT TRANSPORT	DODGE CARAVAN W/ LIFTS 2	2010	34,631	5,844	5,844			5,844	79
80	TOTALS			$ 106,343	$ 10,807	$ 10,807	$		$ 61,427	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)	$ 6,957,297	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 201,203	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 201,203	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,978,048	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 VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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.	/2011	$
13.	/2012	$
14.	/2013	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	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 VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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			hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist			hrs							2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist			hrs							4
5	Physician Care	LINE 39(8)	52	visits			24,000		52	24,000	5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify):										12
13	Other (specify):										13
14	TOTAL				$		$ 24,000	$	52	$ 24,000	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 VERMILION MANOR NURSING HOME **#** 0000786 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/10 **(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	$ 1,859,188	$	1
2	Cash-Patient Deposits	27,440		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000)	1,651,405		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): PROPERTY TAX RECEIVABL	692,778		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,230,811	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,614,959		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,342,338		16
17	Accumulated Depreciation (book methods)	(5,978,048)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 979,249	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,210,060	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 596,859	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,440		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	212,821		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO OTHER FUNDS	689,362		36
37	DEFERRED REVENUE	692,778		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,219,260	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,219,260	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,990,800	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,210,060	$	48

***(See instructions.)**

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 **Report Period Beginning:** 12/1/09 **Ending:** 11/30/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,166,528	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,166,528	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(175,728)	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)**	$ (175,728)	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)**	$ 2,990,800	24 *

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,597,849	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,597,849	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***	32,976	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 32,976	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS - SEE ATTACHED	20,298	28
28a	PROPERTY TAX REVENUE	692,073	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 712,371	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,343,196	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,908,468	31
32	Health Care	5,575,166	32
33	General Administration	1,703,827	33
	B. Capital Expense		
34	Ownership	201,657	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	129,806	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,518,924	40
41	**Income before Income Taxes (line 30 minus line 40)****	(175,728)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (175,728)	43

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

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

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

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

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	1,929	2,227	$ 73,681	$ 33.09	1
2	Assistant Director of Nursing	1,490	1,547	41,412	26.77	2
3	Registered Nurses	37,195	40,687	1,094,197	26.89	3
4	Licensed Practical Nurses	27,268	30,108	531,857	17.66	4
5	CNAs & Orderlies	131,009	145,028	1,702,746	11.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,571	3,983	43,639	10.96	8
9	Activity Director	1,773	2,113	20,938	9.91	9
10	Activity Assistants	4,752	5,324	61,371	11.53	10
11	Social Service Workers	10,582	12,133	124,388	10.25	11
12	Dietician					12
13	Food Service Supervisor	7,512	8,033	102,214	12.72	13
14	Head Cook	8,838	9,629	101,336	10.52	14
15	Cook Helpers/Assistants	35,613	39,364	367,233	9.33	15
16	Dishwashers					16
17	Maintenance Workers	10,160	15,115	153,129	10.13	17
18	Housekeepers	16,965	18,694	181,639	9.72	18
19	Laundry	11,155	12,179	110,702	9.09	19
20	Administrator	1,920	2,080	78,251	37.62	20
21	Assistant Administrator	1,854	2,126	69,253	32.57	21
22	Other Administrative					22
23	Office Manager	2,049	2,315	50,304	21.73	23
24	Clerical	3,626	4,368	58,392	13.37	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	2,027	2,425	32,839	13.54	31
32	Other Health Care(specify)	3,765	4,384	114,256	26.06	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	325,053	363,862	$ 5,113,777 *	$ 14.05	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		$ 61,528		35
36	Medical Director		24,000		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				44
45	Social Service Consultant				45
46	Other(specify) FR&R		2,250		46
47	DR. ALBERT LO		200		47
48	COMPUTER SUPPORT		79,615		48
49	TOTAL (lines 35 - 48)		$ 167,593		49

C. CONTRACT NURSES

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOAN DARR	ADMINISTRATOR		$ 78,251
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 78,251

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
FR&R	MEDICAL CONSULTANT	$ 2,250
DR. ALBERT LO	MEDICAL CONSULTANT	200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 2,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,977
Unemployment Compensation Insurance	43,268
FICA Taxes	361,715
Employee Health Insurance	273,507
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	420,426
EMPLOYEE FRINGE BENEFITS	6,366
EMPLOYEE PHYSICALS	301
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,197,560

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,591
Health Care Worker Background Check	
(Indicate # of checks performed 150)	3,000
Patient Background Checks	
DUES AND FEES	30,099
STATE MARSHALL	350
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,040

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	275
Seminar Expense	347
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 622

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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8													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/09 Ending: 11/30/10

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES, EXCEPT RN'S**

(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? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **44,783** Line **10/2**

(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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **129,806**
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. $ **0** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **75%**
d. Have vehicle usage logs been maintained? **YES**
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: **CLIFTON GUNDERSON**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees