

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786 Report Period Beginning: 12/1/10 Ending: 11/30/11

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	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	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	6,186	83	8,381	14,650	8
9	SNF/PED					9
10	ICF	37,426	8,306	354	46,086	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	43,612	8,389	8,735	60,736	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.06%

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

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

I. On what date did you start providing long term care at this location?
Date started 01/01/1974

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 142 and days of care provided 6,517

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCURAL MODIFIED CASH* CASH*

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

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
1	A. General Services										
1	Dietary	564,423	47,291	48,250	659,964		659,964		659,964		1
2	Food Purchase		489,534		489,534		489,534		489,534		2
3	Housekeeping	190,667	38,812		229,479		229,479		229,479		3
4	Laundry	113,782	25,525		139,307		139,307		139,307		4
5	Heat and Other Utilities			233,274	233,274	(426)	232,848	(11,644)	221,204		5
6	Maintenance	148,127	32,217	103,676	284,020		284,020		284,020		6
7	Other (specify):*			35,870	35,870		35,870		35,870		7
8	TOTAL General Services	1,016,999	633,379	421,070	2,071,448	(426)	2,071,022	(11,644)	2,059,378		8
9	B. Health Care and Programs										
9	Medical Director			24,000	24,000	(24,000)					9
10	Nursing and Medical Records	3,818,408	857,757	64,977	4,741,142		4,741,142		4,741,142		10
10a	Therapy	47,150		1,123,601	1,170,751		1,170,751		1,170,751		10a
11	Activities	88,405		2,807	91,212		91,212		91,212		11
12	Social Services	132,799		1,169	133,968		133,968		133,968		12
13	CNA Training										13
14	Program Transportation			120	120		120		120		14
15	Other (specify):* Plan Coordinator	125,249			125,249		125,249		125,249		15
16	TOTAL Health Care and Programs	4,212,011	857,757	1,216,674	6,286,442	(24,000)	6,262,442		6,262,442		16
17	C. General Administration										
17	Administrative	78,256			78,256		78,256		78,256		17
18	Directors Fees										18
19	Professional Services			5,150	5,150		5,150		5,150		19
20	Dues, Fees, Subscriptions & Promotions			25,323	25,323		25,323		25,323		20
21	Clerical & General Office Expenses	158,791	26,155	123,643	308,589		308,589		308,589		21
22	Employee Benefits & Payroll Taxes			1,274,807	1,274,807		1,274,807		1,274,807		22
23	Inservice Training & Education			925	925		925		925		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			11,875	11,875		11,875		11,875		25
26	Insurance-Prop.Liab.Malpractice			54,777	54,777		54,777		54,777		26
27	Other (specify):* Bad Debt			173,340	173,340		173,340	(173,340)			27
28	TOTAL General Administration	237,047	26,155	1,669,840	1,933,042		1,933,042	(173,340)	1,759,702		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,466,057	1,517,291	3,307,584	10,290,932	(24,426)	10,266,506	(184,984)	10,081,522		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership			202,877	202,877		202,877		202,877			30
31	Depreciation											31
32	Amortization of Pre-Op. & Org.											32
33	Interest											33
34	Real Estate Taxes											34
35	Rent-Facility & Grounds											35
36	Rent-Equipment & Vehicles											36
36	Other (specify):*											36
37	TOTAL Ownership			202,877	202,877		202,877		202,877			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					426	426		426			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,683	129,683		129,683		129,683			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			129,683	129,683	24,426	154,109		154,109			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,466,057	1,517,291	3,640,144	10,623,492		10,623,492	(184,984)	10,438,508			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: 12/1/10

Ending: 11/30/11

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(11,644)	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 Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(173,340)	V27		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)	\$ (184,984)		\$	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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (184,984)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops			426	V5	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)			\$ 426		47

VERMILION MANOR NURSING HOME

ID# 0000786

Report Period Beginning: 12/1/10

Ending: 11/30/11

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

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
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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	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: 12/1/10 Ending: 11/30/11

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	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: 12/1/10 Ending: 11/30/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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.)

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 2010 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 2011 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:		2006	N/A	8	
		2007	N/A	9	
		2008	N/A	10	
		2009	N/A	11	
		2010	N/A	12	
FOR BHF USE ONLY					
		13	FROM R. E. TAX STATEMENT FOR 2010	\$	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.**

2010 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 2010 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 2010.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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

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

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	INFORMATION NOT AVAILABLE			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/10

Ending:

11/30/11

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	142	1974	1974	\$ 2,290,108	\$ 57,253	40	\$ 57,253		\$ 2,166,049
5	95	1979	1979	1,961,500	49,038	40	49,038		1,589,026
6									
7									
8									
	Improvement Type**								
9	PARKING LOT/GARAGE		1980	16,200		10			16,200
10	CONSTRUCTION		1980	92,111	2,303	40	2,303		73,691
11	FINAL CONSTRUCTION BILLS		1981	6,000	150	40	150		4,650
12	ROOF		1982	40,042		10			40,042
13	PUMP		1982	9,414		10			9,414
14	ROOF		1983	39,569		10			39,569
15	ROOF		1984	52,663		10			52,663
16	WATER HEATER		1985	26,025		10			26,025
17	DRIVEWAY		1985	4,200		10			4,200
18	FASTEN EATIA SYSTEM		1985	1,438		10			1,438
19	WATER LINE		1986	2,904		10			2,904
20	ACQUAMATIC		1986	2,386		10			2,386
21	FENCE		1986	609		10			609
22	LINT CATCHER		1986	5,981		10			5,981
23	PARKING LOT		1986	26,927		10			26,927
24	ROOF		1986	3,470		10			3,470
25	KITCHEN DUCT WORK		1986	2,644		10			2,644
26	400 AMP LINE		1988	3,400		20			3,400
27	PVC RUB RAILS		1988	2,821		20			2,821
28	CANOPY REPAIR		1988	12,075		20			12,075
29	REPLATE CERAMIC TILES		1988	2,485		20			2,485
30	ELECTRIC		1988	2,030		20			2,030
31	REPAIR CERAMIC TILES		1988	4,387		20			4,387
32	CONDITIONER		1988	17,116		20			17,116
33	WATER METER		1988	1,457		15			1,457
34	BUILDING IMPROVEMENTS		1989	334		20			334
35	DOOR O'MATIC		1989	1,763		20			1,763
36	AIR CONDITIONERS		1989	146,034		20			146,034

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

See Page 12A, Line 70 for total

**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:

12/1/10

Ending:

11/30/11

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FIRE RATED DOOR	1990	\$ 358	\$	20	\$	\$	\$ 358	37
38	BUILDING IMPROVEMENTS	1990	163		20			163	38
39	WINDOW	1990	198		20			198	39
40	AIR CONDITIONERS	1990	14,149		20			14,149	40
41	CAPITAL IMPROVEMENTS	1990	18,139		20			18,139	41
42	HOT WATER STORAGE TANK	1990	4,589		20			4,589	42
43	NEW AIR CONDITIONER	1990	6,602		20			6,602	43
44	ROOF REPAIR	1991	10,500	88	20	88		10,500	44
45	FIRE HYDRANT	1991	2,185	18	20	18		2,185	45
46	PUMPS	1991	1,700	21	20	21		1,700	46
47	AIR CONDITIONERS	1991	9,217	269	20	269		9,217	47
48	LOCK ON SERVICE DOOR	1991	55	2	20	2		55	48
49	CAPITAL IMPROVEMENTS	1991	1,370	57	20	57		1,370	49
50	FIRE DOOR AND SENSORS	1991	1,586	66	20	66		1,586	50
51	SHEETROCK AND BUILDING MATERIALS	1991	143	6	20	6		143	51
52	SIGNS	1991	122	6	20	6		122	52
53	LIGHT FIXTURES	1991	180	8	20	8		180	53
54	CAPITAL IMPROVEMENTS	1991	899	41	20	41		899	54
55	PLUMBING	1991	7,162	328	20	328		7,162	55
56	CORNER GUARDS	1991	367	17	20	17		367	56
57	AIR HANDLER	1991	3,661	183	20	183		3,661	57
58	CAPITAL IMPROVEMENTS	1992	4,880	244	20	244		4,839	58
59	GENERATOR	1992	19,380	969	20	969		19,138	59
60	PLUMBING	1992	11,543	577	20	577		11,399	60
61	PLUMBING	1992	21,222	1,061	20	1,061		20,868	61
62	GENERATOR	1992	46,548	2,327	20	2,327		45,578	62
63	PLUMBING	1992	21,293	1,065	20	1,065		20,850	63
64	IMPROVEMENTS	1992	11,616	581	20	581		11,374	64
65	LIGHT FIXTURES	1992	1,395	70	20	70		1,360	65
66	PLUMBING	1992	8,826	441	20	441		8,606	66
67	AIR CONDITIONERS	1992	2,765	138	20	138		2,661	67
68	AIR CONDITIONERS	1992	5,368	268	20	268		5,167	68
69	IMPROVEMENTS	1992	4,452	223	20	223		4,248	69
70	TOTAL (lines 4 thru 69)		\$ 5,020,726	\$ 117,818		\$ 117,818	\$	\$ 4,501,223	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:

12/1/10

Ending:

11/30/11

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward	\$ 5,020,726	\$ 117,818		\$ 117,818	\$	\$ 4,501,223		1
2	REROOFING PLANS	1993 4,000	200	20	200		3,750		2
3	WALK IN FREEZER	1993 11,400	570	20	570		10,640		3
4	CALL MASTER	1993 3,215		15			3,215		4
5	MISC CAPITAL IMPROVEMENTS	1993 4,968	248	20	248		4,595		5
6	ROOFING	1993 32,207	1,610	20	1,610		29,657		6
7	ROOFING SUPERVISION	1993 2,775	139	20	139		2,555		7
8	SMOKING ROOM PARTS & LAB	1993 6,511	326	20	326		5,996		8
9	LOUNGE WALL/SUPPLIES	1993 1,004	50	20	50		916		9
10	PTS/LABOR KITCHEN	1993 4,984	249	20	249		4,506		10
11	80 GAL HOT WATER HEATER	1994 5,987	299	20	299		5,289		11
12	REG ACTIVATOR	1994 1,190	59	20	59		1,051		12
13	LABOT DAMPER	1994 3,082	154	20	154		2,684		13
14	CALL SYSTEM	1994 3,427	171	20	171		2,913		14
15	GARAGE	1994 4,050	203	20	203		3,443		15
16	ROOFING WORK	1994 38,981	1,949	20	1,949		33,134		16
17	DOOR OPENER	1994 2,849	142	20	142		2,422		17
18	MISC CAPITAL IMPROVEMENTS	1994 4,952	248	20	248		4,209		18
19	GARAGE	1994 1,403	70	20	70		1,192		19
20	BOOSTER HEATER	1995 4,320		10			4,320		20
21	CALL LIGHT SYSTEM	1995 3,577		10			3,577		21
22	FOLDING PARTITION	1995 4,880		10			4,880		22
23	REWIRE GARAGE	1995 650	33	20	33		520		23
24	EXHAUST SYSTEM	1996 5,346		10			5,346		24
25	CONCRETE WORK	1996 1,050	41	15	41		1,050		25
26	CONCRETE WORK - DRIVEWAY	1996 10,170	452	15	452		10,170		26
27	CANOPY	1996 19,619	1,090	15	1,090		19,619		27
28	TILE REPLACEMENT	1996 1,129		10			1,129		28
29	ROOF REPAIR	1997 30,645	1,532	20	1,532		22,090		29
30	REPAIR DRIVE	1997 2,900		10			2,900		30
31	AIR CONDITIONER	1997 15,322	766	20	766		10,917		31
32	WATER HEATER	1998 6,200		10			6,200		32
33	ROOF	1998 21,809		10			21,809		33
34	TOTAL (lines 1 thru 33)	\$ 5,285,328	\$ 128,419		\$ 128,419	\$	\$ 4,737,917		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:

12/1/10

Ending:

11/30/11

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 5,285,328	\$ 128,419		\$ 128,419	\$	\$ 4,737,917	1
2	AIR CONDITIONER	1998	9,160	458	20	458		5,992	2
3	AIR CONDITIONER	1998	8,580	429	20	429		5,577	3
4	CAPITAL IMPROVEMENTS	1998	1,012		10			1,012	4
5	AIR CONDITIONER	1999	49,921	2,496	20	2,496		30,785	5
6	NEW ROOF	1999	22,973	1,149	20	1,149		14,167	6
7	CANOPY REPAIR	1999	7,630	382	20	382		4,673	7
8	GENERATOR	2000	7,951	398	20	398		4,605	8
9	WATER HEATER	2000	8,368	418	20	418		4,742	9
10	CONDENSER	2000	2,350	118	20	118		1,322	10
11	CANOPY REPAIR	2001	7,700	513	15	513		5,561	11
12	WATER HEATER	2001	1,634	68	10	68		1,634	12
13	ELECTRIC BOOSTER HEATER	2001	1,639	96	10	96		1,639	13
14	BOILER REPAIR	2001	23,800	1,587	15	1,587		16,131	14
15	AIR CONDITIONER	2002	8,367	418	20	418		3,765	15
16	LIGHTING	2002	8,402	420	20	420		3,781	16
17	PARKING LOT IMPROVEMENT	2003	4,800	320	15	320		2,640	17
18	BOILERS	2004	2,529	169	15	169		1,335	18
19	CARPETING	2004	1,564	156	10	156		1,095	19
20	WATER HEATER	2004	4,807	481	10	481		3,365	20
21	SPRINKLER SYSTEM	2004	103,956	10,396	10	10,396		72,770	21
22	COMMUNUTOR FOR WASTE TREATMENT SYS	2010	11,338	1,134	10	1,134		1,984	22
23	KITCHEN EXHAUST FAN	2010	5,350	535	10	535		624	23
24	FIRE ALARM UPGRADE	2010	25,800	2,580	10	2,580		3,010	24
25	STEEL DOOR, SCREWS, NAILS, PLYWOOD	2011	2,642	176	10	176		176	25
26	ELECTRICAL OUTLETS	2011	5,799	290	10	290		290	26
27	SEWER ROUTER	2011	534	22	10	22		22	27
28	ELECTRICAL EQUIPMENT	2011	5,628	281	10	281		281	28
29	WINDOW A/C	2011	826	55	5	55		55	29
30	LABOR AND MATERIAL FOR DRAIN LINE REPAIR	2011	21,514	896	10	896		896	30
31	REPAIRS	2011	1,023	51	10	51		51	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,652,925	\$ 154,911		\$ 154,911	\$	\$ 4,931,897	34

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

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	\$ 780,331	\$ 31,604	\$ 31,604	\$	VARIOUS	\$ 715,575	71
72	Current Year Purchases	38,226	4,473	4,473			4,473	72
73	Fully Depreciated Assets	455,664					455,664	73
74								74
75	TOTALS	\$ 1,274,221	\$ 36,077	\$ 36,077	\$		\$ 1,175,712	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	RESIDENT TRANSPORTATION	FORD VAN 1996	1996	\$ 22,296	\$	\$	\$	5	\$ 22,296	76
77	RESIDENT TRANSPORTATION	VAN W/ LIFTS	2002	24,602				5	24,602	77
78	MAINTENANCE	2009 FORD TRUCK	2009	24,814	4,963	4,963		5	13,648	78
79	RESIDENT TRANSPORTATION	10 DODGE CARAVAN W/LIFTS	2010	34,631	6,926	6,926		5	12,770	79
80	TOTALS			\$ 106,343	\$ 11,889	\$ 11,889	\$		\$ 73,316	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)	\$ 7,033,489	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 202,877	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 202,877	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)	\$ 6,180,925	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ 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

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.	<u> </u> /2012	\$ _____
13.	<u> </u> /2013	\$ _____
14.	<u> </u> /2014	\$ _____

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$ _____

D. NUMBER OF CNAs TRAINED

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

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

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

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

1	Service	Schedule V Line & Column Reference	2 Staff		4 Outside Practitioner (other than consultant)		6 Supplies (Actual or) Allocated	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	5					
					Units	Cost				
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 prescripts							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.

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 482,777	\$	1
2	Cash-Patient Deposits	28,627		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000)	4,147,613		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 RECEIVABLE	692,778		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 5,351,795	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,652,925		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,380,564		16
17	Accumulated Depreciation (book methods)	(6,180,925)		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)	\$ 852,564	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,204,359	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 1,167,597	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,627		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,665		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	377,362		36
37	DEFERRED REVENUE	692,778		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,483,029	\$	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)	\$ 2,483,029	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,721,330	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,204,359	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 3,116,673	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 3,116,673	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	604,657	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)	\$ 604,657	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)	\$ 3,721,330	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,466,218	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,466,218	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***	48,113	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 48,113	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS - SEE ATTACHED	15,840	28
28a	PROPERTY TAX REVENUE	697,978	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 713,818	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,228,149	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,071,448	31
32	Health Care	6,286,442	32
33	General Administration	1,933,042	33
B. Capital Expense			
34	Ownership	202,877	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	129,683	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,623,492	40
41	Income before Income Taxes (line 30 minus line 40)**	604,657	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 604,657	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.

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,865	2,192	\$ 67,490	\$ 30.79	1
2	Assistant Director of Nursing	2,947	3,273	63,424	19.38	2
3	Registered Nurses	46,957	50,978	1,187,119	23.29	3
4	Licensed Practical Nurses	21,783	23,853	617,000	25.87	4
5	CNAs & Orderlies	141,958	158,003	1,848,546	11.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,915	4,389	47,150	10.74	8
9	Activity Director	1,783	2,152	21,386	9.94	9
10	Activity Assistants	6,815	7,474	67,019	8.97	10
11	Social Service Workers	9,882	11,290	132,799	11.76	11
12	Dietician					12
13	Food Service Supervisor	8,196	8,911	106,170	11.91	13
14	Head Cook	8,099	8,765	81,671	9.32	14
15	Cook Helpers/Assistants	37,370	40,725	376,582	9.25	15
16	Dishwashers					16
17	Maintenance Workers	9,527	14,487	148,127	10.22	17
18	Housekeepers	17,004	18,937	190,667	10.07	18
19	Laundry	11,313	12,286	113,782	9.26	19
20	Administrator	1,920	2,080	78,256	37.62	20
21	Assistant Administrator	1,491	1,745	58,228	33.37	21
22	Other Administrative					22
23	Office Manager	1,977	2,176	43,731	20.10	23
24	Clerical	3,704	4,261	56,832	13.34	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	2,055	2,507	34,829	13.89	31
32	Other Health Care(specify)	3,953	4,502	125,249	27.82	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	344,514	384,986	\$ 5,466,057 *	\$ 14.20	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 48,250		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) <u>FR&R</u>	5,150		46
47	<u>Computer Support</u>	95,485		47
48				48
49	TOTAL (lines 35 - 48)	\$ 172,885		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	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: 12/1/10

Ending: 11/30/11

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. \$ 48,912 Line _____
- (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. \$ 129,683
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?
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: CliftonLarsonAllen LLP
- (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.