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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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: TRACY MCCRAE **Telephone Number:** (217) 443-6460
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 12/1/11 to 11/30/12 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) TRACY MCCRAE
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (Date)
(Print Name and Title) SEE ATTACHED ACCOUNTANTS REPORT
(Firm Name & Address) CliftonLarsonAllen, 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: 12/1/11 Ending: 11/30/12

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	6,144	259	5,897	12,300	8
9	SNF/PED					9
10	ICF	37,899	9,565	693	48,157	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,043	9,824	6,590	60,457	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.74%

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 01/01/1974

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 142 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: 12/1/11-11/30/12

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

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

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	505,010	43,884	63,513	612,407		612,407		612,407			1
2	Food Purchase		441,723		441,723		441,723		441,723			2
3	Housekeeping	175,651	37,831		213,482		213,482		213,482			3
4	Laundry	115,924	23,730		139,654		139,654		139,654			4
5	Heat and Other Utilities			154,802	154,802	(256)	154,546	(14,247)	140,299			5
6	Maintenance	152,797	35,736	144,385	332,918		332,918		332,918			6
7	Other (specify):*			38,734	38,734		38,734		38,734			7
8	TOTAL General Services	949,382	582,904	401,434	1,933,720	(256)	1,933,464	(14,247)	1,919,217			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000	(24,000)						9
10	Nursing and Medical Records	3,570,593	758,093	44,789	4,373,475		4,373,475		4,373,475			10
10a	Therapy	56,316		1,141,885	1,198,201		1,198,201		1,198,201			10a
11	Activities	87,162		873	88,035		88,035		88,035			11
12	Social Services	122,035		1,214	123,249		123,249		123,249			12
13	CNA Training											13
14	Program Transportation			120	120		120		120			14
15	Other (specify):* Plan Coordinator	126,188			126,188		126,188		126,188			15
16	TOTAL Health Care and Programs	3,962,294	758,093	1,212,881	5,933,268	(24,000)	5,909,268		5,909,268			16
	C. General Administration											
17	Administrative	101,044			101,044		101,044		101,044			17
18	Directors Fees											18
19	Professional Services			5,015	5,015		5,015		5,015			19
20	Dues, Fees, Subscriptions & Promotions			5,984	5,984		5,984		5,984			20
21	Clerical & General Office Expenses	128,322	24,966	37,366	190,654		190,654		190,654			21
22	Employee Benefits & Payroll Taxes			1,257,778	1,257,778		1,257,778		1,257,778			22
23	Inservice Training & Education			1,814	1,814		1,814		1,814			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			14,091	14,091		14,091		14,091			25
26	Insurance-Prop.Liab.Malpractice			55,200	55,200		55,200		55,200			26
27	Other (specify):*			605,136	605,136		605,136	(605,136)				27
28	TOTAL General Administration	229,366	24,966	1,982,384	2,236,716		2,236,716	(605,136)	1,631,580			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,141,042	1,365,963	3,596,699	10,103,704	(24,256)	10,079,448	(619,383)	9,460,065			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: 12/1/11 Ending: 11/30/12

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			196,275	196,275		196,275		196,275			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			196,275	196,275		196,275		196,275			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					256	256		256			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,056	117,056		117,056		117,056			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			117,056	117,056	24,256	141,312		141,312			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,141,042	1,365,963	3,910,030	10,417,035		10,417,035	(619,383)	9,797,652			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: 12/1/11 Ending: 11/30/12

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,247)	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	(605,136)	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)**	$ (619,383)		$	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))**	$ (619,383)		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			256	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)**			$ 256		47

STATE OF ILLINOIS

VERMILION MANOR NURSING HOME

ID# 0000786

Report Period Beginning: 12/1/11

Ending: 11/30/12

	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:** 12/1/11 **Ending:** 11/30/12

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:** 12/1/11 **Ending:** 11/30/12

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: 12/1/11 Ending: 11/30/12

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 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: 12/1/11 Ending: 11/30/12

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

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

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: 12/1/11 Ending: 11/30/12

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: 12/1/11 Ending: 11/30/12

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	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: 12/1/11 Ending: 11/30/12

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 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 2012 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:		
2007	N/A	8
2008	N/A	9
2009	N/A	10
2010	N/A	11
2011	N/A	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 12/1/11 Ending: 11/30/12

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: 12/1/11 Ending: 11/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	142		1974	1974	$ 2,290,108	$ 57,253	40	$ 57,253	$	$ 2,223,302	4
5	95		1979	1979	1,961,500	49,038	40	49,038		1,638,063	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		75,994	10
11	FINAL CONSTRUCTION BILLS			1981	6,000	150	40	150		4,800	11
12	ROOF			1982	40,042		10			40,042	12
13	PUMP			1982	9,414		10			9,414	13
14	ROOF			1983	39,569		10			39,569	14
15	ROOF			1984	52,663		10			52,663	15
16	WATER HEATER			1985	26,025		10			26,025	16
17	DRIVEWAY			1985	4,200		10			4,200	17
18	FASTEN EATIA SYSTEM			1985	1,438		10			1,438	18
19	WATER LINE			1986	2,904		10			2,904	19
20	ACQUAMATIC			1986	2,386		10			2,386	20
21	FENCE			1986	609		10			609	21
22	LINT CATCHER			1986	5,981		10			5,981	22
23	PARKING LOT/GARAGE			1986	26,927		10			26,927	23
24	ROOF			1986	3,470		10			3,470	24
25	KITCHEN DUCT WORK			1986	2,644		10			2,644	25
26	400 AMP LINE			1988	3,400		20			3,400	26
27	PVC RUB RAILS			1988	2,821		20			2,821	27
28	CANOPY REPAIR			1988	12,075		20			12,075	28
29	REPLATE CERAMIC TILES			1988	2,485		20			2,485	29
30	ELECTRIC			1988	2,030		20			2,030	30
31	REPAIR CERAMIC TILES			1988	4,387		20			4,387	31
32	CONDITIONER			1988	17,116		20			17,116	32
33	WATER METER			1988	1,457		15			1,457	33
34	BUILDING IMPROVEMENTS			1989	334		20			334	34
35	DOOR O'MATIC			1989	1,763		20			1,763	35
36	AIR CONDITIONERS			1989	146,034		20			146,034	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: 12/1/11 Ending: 11/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	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		20			10,500	44
45	FIRE HYDRANT	1991	2,185		20			2,185	45
46	PUMPS	1991	1,700		20			1,700	46
47	AIR CONDITIONERS	1991	9,217		20			9,217	47
48	LOCK ON SERVICE DOOR	1991	55		20			55	48
49	CAPITAL IMPROVEMENTS	1991	1,370		20			1,370	49
50	FIRE DOOR AND SENSORS	1991	1,586		20			1,586	50
51	SHEETROCK AND BUILDING MATERIALS	1991	143		20			143	51
52	SIGNS	1991	122		20			122	52
53	LIGHT FIXTURES	1991	180		20			180	53
54	CAPITAL IMPROVEMENTS	1991	899		20			899	54
55	PLUMBING	1991	7,162		20			7,162	55
56	CORNER GUARDS	1991	367		20			367	56
57	AIR HANDLER	1991	3,661		20			3,661	57
58	CAPITAL IMPROVEMENTS	1992	4,880	41	20	41		4,880	58
59	GENERATOR	1992	19,380	242	20	242		19,380	59
60	PLUMBING	1992	11,543	144	20	144		11,543	60
61	PLUMBING	1992	21,222	354	20	354		21,222	61
62	GENERATOR	1992	46,548	970	20	970		46,548	62
63	PLUMBING	1992	21,293	444	20	444		21,293	63
64	IMPROVEMENTS	1992	11,616	242	20	242		11,616	64
65	LIGHT FIXTURES	1992	1,395	35	20	35		1,395	65
66	PLUMBING	1992	8,826	221	20	221		8,826	66
67	AIR CONDITIONERS	1992	2,765	104	20	104		2,765	67
68	AIR CONDITIONERS	1992	5,368	201	20	201		5,368	68
69	IMPROVEMENTS	1992	4,452	204	20	204		4,452	69
70	TOTAL (lines 4 thru 69)		$ 5,020,726	$ 111,946		$ 111,946	$	$ 4,613,166	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: 12/1/11 Ending: 11/30/12

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,020,726	$ 111,946		$ 111,946	$	$ 4,613,166	1
2	REROOFING PLANS	1993	4,000	200	20	200		3,950	2
3	WALK IN FREEZER	1993	11,400	570	20	570		11,210	3
4	CALL MASTER	1993	3,215		15			3,215	4
5	MISC CAPITAL IMPROVEMENTS	1993	4,968	248	20	248		4,844	5
6	ROOFING	1993	32,207	1,610	20	1,610		31,268	6
7	ROOFING SUPERVISION	1993	2,775	139	20	139		2,694	7
8	SMOKING ROOM PARTS & LAB	1993	6,511	326	20	326		6,321	8
9	LOUNGE WALL/SUPPLIES	1993	1,004	50	20	50		967	9
10	PTS/LABOR KITCHEN	1993	4,984	249	20	249		4,756	10
11	80 GAL HOT WATER HEATER	1994	5,987	299	20	299		5,588	11
12	REG ACTIVATOR	1994	1,190	59	20	59		1,110	12
13	LABOT DAMPER	1994	3,082	154	20	154		2,838	13
14	CALL SYSTEM	1994	3,427	171	20	171		3,084	14
15	GARAGE	1994	4,050	202	20	202		3,644	15
16	ROOFING WORK	1994	38,981	1,949	20	1,949		35,083	16
17	DOOR OPENER	1994	2,849	142	20	142		2,564	17
18	MISC CAPITAL IMPROVEMENTS	1994	4,952	248	20	248		4,457	18
19	GARAGE	1994	1,403	70	20	70		1,263	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		553	23
24	EXHAUST SYSTEM	1996	5,346		10			5,346	24
25	CONCRETE WORK	1996	1,050		15			1,050	25
26	CONCRETE WORK - DRIVEWAY	1996	10,170		15			10,170	26
27	CANOPY	1996	19,619		15			19,619	27
28	TILE REPLACEMENT	1996	1,129		10			1,129	28
29	ROOF REPAIR	1997	30,645	1,532	20	1,532		23,622	29
30	REPAIR DRIVE	1997	2,900		10			2,900	30
31	AIR CONDITIONER	1997	15,322	766	20	766		11,683	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	$ 120,963		$ 120,963	$	$ 4,858,880	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: 12/1/11 Ending: 11/30/12

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,285,328	$ 120,963		$ 120,963	$	$ 4,858,880	1
2	AIR CONDITIONER	1998	9,160	458	20	458		6,450	2
3	AIR CONDITIONER	1998	8,580	429	20	429		6,006	3
4	CAPITAL IMPROVEMENTS	1998	1,012		10			1,012	4
5	AIR CONDITIONER	1999	49,921	2,496	20	2,496		33,281	5
6	NEW ROOF	1999	22,973	1,149	20	1,149		15,315	6
7	CANOPY REPAIR	1999	7,630	382	20	382		5,055	7
8	GENERATOR	2000	7,951	398	20	398		5,003	8
9	WATER HEATER	2000	8,368	418	20	418		5,160	9
10	CONDENSER	2000	2,350	118	20	118		1,439	10
11	CANOPY REPAIR	2001	7,700	513	15	513		6,074	11
12	WATER HEATER	2001	1,634		10			1,634	12
13	ELECTRIC BOOSTER HEATER	2001	1,639		10			1,639	13
14	BOILER REPAIR	2001	23,800	1,587	15	1,587		17,718	14
15	AIR CONDITIONER	2002	8,367	418	20	418		4,184	15
16	LIGHTING	2002	8,402	420	20	420		4,201	16
17	PARKING LOT IMPROVEMENT	2003	4,800	320	15	320		2,960	17
18	BOILERS	2004	2,529	169	15	169		1,503	18
19	CARPETING	2004	1,564	156	10	156		1,251	19
20	WATER HEATER	2004	4,807	481	10	481		3,846	20
21	SPRINKLER SYSTEM	2004	103,956	10,396	10	10,396		83,165	21
22	COMMINUTOR FOR WASTE TREATEMENT SYS	2010	11,338	1,134	10	1,134		3,118	22
23	KITCHEN EXHAUST FAN	2010	5,350	535	10	535		1,159	23
24	FIRE ALARM UPGRADE	2010	25,800	2,580	10	2,580		5,590	24
25	STEEL DOOR, SCREWS, NAILS, PLYWOOD	2011	2,642	264	10	264		440	25
26	ELECTRICAL OUTLETS	2011	5,799	580	10	580		870	26
27	SEWER ROUTER	2011	534	53	10	53		76	27
28	ELECTRICAL EQUIPMENT	2011	5,628	563	10	563		844	28
29	WINDOW A/C	2011	826	165	5	165		220	29
30	LABOR AND MATERIAL FOR DRAIN LINE REPAIR	2011	21,514	2,151	10	2,151		3,048	30
31	REPAIRS	2011	1,023	102	10	102		154	31
32	ROOF	2012	175,790		20				32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,828,715	$ 149,398		$ 149,398	$	$ 5,081,295	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: 12/1/11 Ending: 11/30/12

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 623,724	$ 32,628	$ 32,628	$	VARIOUS	$ 733,632	71
72	Current Year Purchases	210,379	2,361	2,361			2,361	72
73	Fully Depreciated Assets	474,707					474,707	73
74								74
75	TOTALS	$ 1,308,810	$ 34,989	$ 34,989	$		$ 1,210,700	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 TRANSPORTAT	FORD VAN 1996	1996	$ 22,296	$	$	$		$ 22,296	76
77	RESIDENT TRANSPORTAT	VAN W/ LIFTS	2002	24,602					24,602	77
78	MAINTENANCE	2009 FORD TRUCK	2009	24,814	4,963	4,963			18,611	78
79	RESIDENT TRANSPORTAT	10 DODGE CARAVAN W/ LIFT	2010	34,631	6,926	6,926			19,696	79
80	TOTALS			$ 106,343	$ 11,889	$ 11,889	$		$ 85,205	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)	$ 7,243,868	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 196,276	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 196,276	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)	$ 6,377,200	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: 12/1/11 Ending: 11/30/12

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: 12/1/11 Ending: 11/30/12

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: 12/1/11 Ending: 11/30/12

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: 12/1/11 Ending: 11/30/12

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/12 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,248,834	$	1
2	Cash-Patient Deposits	29,069		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 175,000)	2,168,172		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)**	$ 5,138,853	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,828,715		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,415,153		16
17	Accumulated Depreciation (book methods)	(6,377,200)		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)**	$ 866,668	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,005,521	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 565,419	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	29,069		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	194,253		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	195,362		36
37	DEFERRED REVENUE	692,778		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,676,881	$	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)**	$ 1,676,881	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,328,640	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,005,521	$	48

*(See instructions.)

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,721,330	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,721,330	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	607,310	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)**	$ 607,310	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)**	$ 4,328,640	24 *

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

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,161,553	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,161,553	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***	11,106	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,106	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**MISCELLANEOUS - SEE ATTACHED**	172,230	28
28a	**PROPERTY TAX REVENUE**	679,456	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 851,686	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,024,345	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,933,720	31
32	Health Care	5,933,268	32
33	General Administration	2,236,716	33
	B. Capital Expense		
34	Ownership	196,275	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	117,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,417,035	40
41	**Income before Income Taxes (line 30 minus line 40)****	607,310	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 607,310	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$	49

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

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

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

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

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

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	1,818	2,116	$ 69,291	$ 32.75	1
2	Assistant Director of Nursing	2,078	2,182	70,996	32.54	2
3	Registered Nurses	37,109	41,382	1,049,418	25.36	3
4	Licensed Practical Nurses	23,428	25,190	569,437	22.61	4
5	CNAs & Orderlies	130,376	140,529	1,776,919	12.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,767	5,264	56,316	10.70	8
9	Activity Director	1,838	2,183	22,546	10.33	9
10	Activity Assistants	6,255	6,902	64,616	9.36	10
11	Social Service Workers	10,118	11,650	122,035	10.48	11
12	Dietician					12
13	Food Service Supervisor	6,974	7,914	88,267	11.15	13
14	Head Cook	9,081	9,960	93,291	9.37	14
15	Cook Helpers/Assistants	28,112	30,823	323,452	10.49	15
16	Dishwashers					16
17	Maintenance Workers	9,550	10,102	152,797	15.13	17
18	Housekeepers	14,666	16,319	175,651	10.76	18
19	Laundry	11,659	12,922	115,924	8.97	19
20	Administrator	1,950	2,240	101,044	45.11	20
21	Assistant Administrator	596	763	24,400	31.98	21
22	Other Administrative					22
23	Office Manager	1,892	2,205	46,507	21.09	23
24	Clerical	3,573	4,315	57,415	13.31	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	2,004	2,143	34,532	16.11	31
32	Other Health Care(specify)	4,715	5,521	126,188	22.86	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	312,559	342,625	$ 5,141,042 *	$ 15.00	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		$ 63,513		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		5,015		46
47	Computer Support		13,720		47
48					48
49	TOTAL (lines 35 - 48)		$ 106,248		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: 12/1/11 Ending: 11/30/12

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TRACY MCCRAE	ADMINISTRATOR		$ 49,728
JOAN DARR	ADMINISTRATOR		51,316
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 101,044

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	$ 5,015
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 5,015

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,073
Unemployment Compensation Insurance	19,653
FICA Taxes	362,495
Employee Health Insurance	326,857
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	482,157
EMPLOYEE FRINGE BENEFITS	6,200
EMPLOYEE PHYSICALS	343
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,257,778

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,669
Health Care Worker Background Check	
(Indicate # of checks performed 100)	1,000
Patient Background Checks	
DUES AND FEES	2,315
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,984

G. Schedule of Travel and Seminar**

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

**See instructions.

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

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													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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

XX. GENERAL INFORMATION:

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

(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. $ 49,721 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. $ 117,056
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.