

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0000786

Facility Name: VERMILION MANOR NURSING HOME

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

County: VERMILION

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

HFS ID Number: 37-6002224-001

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

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input checked="" type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: JOAN DARR **Telephone Number:** 217-443-6430

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/05 to 11/30/06 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) _____

(Type or Print Name) JOAN DARR

(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date) _____

(Print Name and Title) SEE ATTACHED ACCOUNTANT'S REPORT

(Firm Name & Address) CLIFTON GUNDERSON LLP
2 E MAIN STREET, SUITE 120, DANVILLE, IL 61832

(Telephone) 217-442-1643 Fax # 217-443-5470

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number VERMILION MANOR NURSING HOME# 0000786 Report Period Beginning: 12/1/05 Ending: 11/30/06

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	<u>138</u>	Skilled (SNF)	<u>138</u>	<u>48,434</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>95</u>	Intermediate (ICF)	<u>95</u>	<u>36,699</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>233</u>	TOTALS	<u>233</u>	<u>85,133</u>	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	<u>2,040</u>	<u>1,170</u>	<u>5,360</u>	<u>8,570</u>	8
9	SNF/PED					9
10	ICF	<u>33,559</u>	<u>8,985</u>		<u>42,544</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>35,599</u>	<u>10,155</u>	<u>5,360</u>	<u>51,114</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 60.04%

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/AF. Does the facility maintain a daily midnight census? YESG. 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 29 and days of care provided 4,857Medicare Intermediary ADMINSTAR

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED
CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: N/A Fiscal Year: 12/1/05-11/30/06

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

Facility Name & ID Number **VERMILION MANOR NURSING HOME** # **0000786** Report Period Beginning: **12/1/05** Ending: **11/30/06**

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 OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	392,043	44,725	21,741	458,509		458,509		458,509			1
2	Food Purchase		269,933		269,933		269,933		269,933			2
3	Housekeeping	124,041	28,744		152,785		152,785		152,785			3
4	Laundry	96,406	17,505		113,911		113,911		113,911			4
5	Heat and Other Utilities			208,911	208,911	(381)	208,530	(13,548)	194,982			5
6	Maintenance	129,648	30,228	19,030	178,906		178,906		178,906			6
7	Other (specify):* WASTE DISPOSAL			54,434	54,434		54,434		54,434			7
8	TOTAL General Services	742,138	391,135	304,116	1,437,389	(381)	1,437,008	(13,548)	1,423,460			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000	(24,000)						9
10	Nursing and Medical Records	3,257,465	509,922	82,141	3,849,528	(7,873)	3,841,655		3,841,655			10
10a	Therapy			314,193	314,193	(405)	313,788		313,788			10a
11	Activities	86,487	340		86,827		86,827		86,827			11
12	Social Services	85,060	1,135		86,195		86,195		86,195			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* PLAN COORDINAT	79,731			79,731		79,731		79,731			15
16	TOTAL Health Care and Programs	3,508,743	511,397	420,334	4,440,474	(32,278)	4,408,196		4,408,196			16
	C. General Administration											
17	Administrative	63,129			63,129		63,129		63,129			17
18	Directors Fees											18
19	Professional Services			3,630	3,630		3,630		3,630			19
20	Dues, Fees, Subscriptions & Promotions			12,857	12,857		12,857		12,857			20
21	Clerical & General Office Expenses	169,050	17,263	43,984	230,297		230,297		230,297			21
22	Employee Benefits & Payroll Taxes			1,063,202	1,063,202		1,063,202		1,063,202			22
23	Inservice Training & Education			1,945	1,945		1,945		1,945			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,917	5,917		5,917		5,917			25
26	Insurance-Prop.Liab.Malpractice			56,461	56,461		56,461		56,461			26
27	Other (specify):* BAD DEBT			41,113	41,113		41,113	(41,113)				27
28	TOTAL General Administration	232,179	17,263	1,229,109	1,478,551		1,478,551	(41,113)	1,437,438			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,483,060	919,795	1,953,559	7,356,414	(32,659)	7,323,755	(54,661)	7,269,094			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: 12/1/05 Ending: 11/30/06

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			205,996	205,996		205,996		205,996			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			205,996	205,996		205,996		205,996			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					381	381		381			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			140,690	140,690		140,690		140,690			42
43	Other (specify):* EXCEPTIONAL CARE EXPENSES					8,278	8,278		8,278			43
44	TOTAL Special Cost Centers			140,690	140,690	32,659	173,349		173,349			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,483,060	919,795	2,300,245	7,703,100		7,703,100	(54,661)	7,648,439			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: 12/1/05

Ending: 11/30/06

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	OHF 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	(13,548)	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	(41,113)	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)	\$ (54,661)		\$	30

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))	\$ (54,661)		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			381	V5(3)	41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program			8,278	V10,10a	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 8,659		47

BHF USE ONLY						
48		49		50		51
						52

STATE OF ILLINOIS
 VERMILION MANOR NURSING HOME

ID# 0000786
 Report Period Beginning: 12/1/05
 Ending: 11/30/06

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	CABLE TV	\$ (13,548)	5	1
2	BAD DEBT	(41,113)	27	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
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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	(54,661)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/05

Ending:

11/30/06

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	(13,548)	0	0	0	0	0	0	0	0	0	0	(13,548)	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	(13,548)	0	0	0	0	0	0	0	0	0	0	(13,548)	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):*	(41,113)	0	0	0	0	0	0	0	0	0	0	(41,113)	27
28	TOTAL General Administration	(41,113)	0	0	0	0	0	0	0	0	0	0	(41,113)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(54,661)	0	0	0	0	0	0	0	0	0	0	(54,661)	29

STATE OF ILLINOIS

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/05

Ending:

Summary B

11/30/06

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(54,661)	0	(54,661)	45									

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/05

Ending:

11/30/06

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1	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		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

* 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: 12/1/05 Ending: 11/30/06

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.

Select Pages to Print

<input type="checkbox"/>	PG1	<input type="button" value="OK"/>
<input type="checkbox"/>	PG2	
<input type="checkbox"/>	PG3	<input type="button" value="Cancel"/>
<input type="checkbox"/>	PG4	
<input type="checkbox"/>	PG5	
<input type="checkbox"/>	PG5A	
<input type="checkbox"/>	Summary_A	
<input type="checkbox"/>	Summary_B	
<input checked="" type="checkbox"/>	PG6	
<input type="checkbox"/>	PG7	
<input checked="" type="checkbox"/>	PG8	
<input type="checkbox"/>	PG9	
<input type="checkbox"/>	PG10	
<input type="checkbox"/>	RE_Tax	
<input type="checkbox"/>	PG11	
<input type="checkbox"/>	PG12	
<input type="checkbox"/>	PG12A	
<input type="checkbox"/>	PG12B	
<input type="checkbox"/>	PG13	
<input type="checkbox"/>	PG14	
<input type="checkbox"/>	PG15	
<input type="checkbox"/>	PG16	
<input type="checkbox"/>	PG17	
<input type="checkbox"/>	PG18	
<input type="checkbox"/>	PG19	
<input type="checkbox"/>	PG20	
<input type="checkbox"/>	PG21	
<input type="checkbox"/>	PG22	
<input type="checkbox"/>	PG23	

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/05 Ending: 11/30/06

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/05 Ending: 11/30/06

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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:

12/1/05 Ending:

11/30/06

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:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>INFORMATION NOT AVAILABLE</u>			\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	138		1974	1974	\$ 2,290,108	\$ 57,253	40	\$ 57,253		\$ 1,879,788	4
5	95		1979	1979	1,961,500	49,038	40	49,038		1,343,842	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		62,179	10
11		FINAL CONSTRUCTION		1981	6,000	150	40	150		3,900	11
12		PUMP		1982	9,414		10			9,414	12
13		ROOF		1982	40,042		10			40,042	13
14		ROOF		1983	39,569		10			39,569	14
15		ROOF		1984	52,663		10			52,663	15
16		WATER HEATER		1985	27,463		10			27,463	16
17		WATER LINE		1985	5,290		10			5,290	17
18		DRIVEWAY		1985	4,200		10			4,200	18
19		LINT CATCHER		1986	5,981		10			5,981	19
20		PARKING LOT/GARAGE		1986	26,927		10			26,927	20
21		ROOF/DUCT WORK		1986	6,114		10			6,114	21
22		FENCE		1986	609		10			609	22
23		PVC RUB RAILS		1988	2,821	141	20	141		2,621	23
24		CERAMIC TILES		1988	6,872	344	20	344		6,274	24
25		TIME CLOCK/COMPUTER		1988	2,030	101	20	101		1,843	25
26		INCREMENTAL CONDITIONER		1988	17,116	856	20	856		15,404	26
27		WATER METER		1988	1,457		15			1,457	27
28		400 AMP LINE		1988	3,400	170	20	170		3,159	28
29		CANOPY REPAIR		1988	12,075	604	20	604		11,170	29
30		DOOR O MATIC		1989	1,763	88	20	88		1,557	30
31		AIR CONDITIONER		1989	146,368	7,318	20	7,318		120,504	31
32		HOT WATER STORAGE TANK		1990	4,589	229	20	229		3,824	32
33		CAPITAL IMPROVEMENT		1990	18,139	906	20	906		15,190	33
34		AIR CONDITIONER UNITS		1991	21,470	1,074	20	1,074		17,818	34
35		PUMPS		1991	1,700	85	20	85		1,339	35
36		AIR CONDITIONER		1991	9,217	461	20	461		7,105	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:

12/1/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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 DOORS AND RELATED IMPROVEMENTS	1991	\$ 4,354	\$ 218	20	\$ 218	\$	\$ 3,299	37
38	PLUMBING	1992	7,162	358	20	358		5,400	38
39	AIR HANDLER/CORNER GUARDS	1991	4,028	201	20	201		3,019	39
40	ROOF REPAIR	1991	10,500	525	20	525		8,313	40
41	FIRE HYDRANT	1991	2,185	109	20	109		1,727	41
42	GENERATOR	1992	70,808	3,540	20	3,540		51,851	42
43	PLUMBING	1992	62,884	3,144	20	3,144		46,000	43
44	LIGHT FIXTURES	1992	1,395	70	20	70		1,013	44
45	AIR CONDITIONERS	1992	24,201	1,210	20	1,210		17,399	45
46	ROOF REPAIR	1993	38,982	1,949	20	1,949		26,216	46
47	WALK IN FREEZER	1993	11,400	570	20	570		7,790	47
48	MASTER STATION IMPROVEMENTS	1993	3,215	214	20	214		2,891	48
49	SMOKING ROOM	1993	6,511	325	20	325		4,367	49
50	LOUNGE WALL	1993	1,004	50	20	50		664	50
51	KITCHEN IMPROVEMENTS	1993	9,952	498	20	498		6,617	51
52	80 GALLON WATER HEATER	1994	5,987	299	20	299		3,789	52
53	ACTIVATOR PARTS	1994	1,190	59	20	59		750	53
54	DAMPERS	1994	3,082	154	20	154		1,913	54
55	CALL SYSTEM	1994	3,427	171	20	171		2,054	55
56	GARAGE	1994	13,254	663	20	663		7,954	56
57	BOOSTER HEATER	1995	4,320		10			4,320	57
58	CALL LIGHT SYSTEM	1995	3,577		10			3,577	58
59	FOLDING PARTITION	1995	4,880		10			4,880	59
60	REWIRE GARAGE	1995	650	33	20	33		361	60
61	EXHAUST SYSTEM	1996	5,347	43	10	43		5,347	61
62	CONCRETE WORK -FRONT ENTRANCE	1996	1,050	70	15	70		729	62
63	CONCRETE WORK -DRIVEWAYS	1996	10,170	678	15	678		7,009	63
64	CANOPY	1996	19,619	1,308	15	1,308		13,298	64
65	TIRE REPLACEMENT	1996	1,129	112	10	112		1,129	65
66	ROOF REPAIR	1997	30,645	1,532	20	1,532		14,427	66
67	AIR CONDITIONER UNITS	1997	15,320	766	20	766		7,086	67
68	REPAIR DRIVE	1997	2,900	290	10	290		2,707	68
69	WATER HEATER	1998	6,200	620	10	620		5,115	69
70	TOTAL (lines 4 thru 69)		\$ 5,224,536	\$ 140,900		\$ 140,900	\$	\$ 4,006,457	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:

12/1/05

Ending:

11/30/06

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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		\$ 5,224,536	\$ 140,900		\$ 140,900	\$	\$ 4,006,457	1
2	CAPITAL IMPROVEMENT	1998	1,013	102	10	102		812	2
3	ROOF	1998	21,809	2,181	10	2,181		17,630	3
4	AIR CONDITIONER UNITS	1998	9,160	458	20	458		3,702	4
5	AIR CONDITIONER UNITS	1998	8,580	429	20	429		3,432	5
6	NEW ROOF	1999	22,973	1,149	20	1,149		8,426	6
7	AIR CONDITIONER UNITS	1999	49,921	2,496	20	2,496		18,304	7
8	CANOPY REPAIR	1999	7,630	382	20	382		2,769	8
9	GENERATOR	2000	7,951	398	20	398		2,620	9
10	WATER HEATER	2000	8,368	418	20	418		2,647	10
11	CONDENSER	2000	2,350	118	20	118		737	11
12	CANOPY REPAIR	2001	7,700	513	15	513		2,993	12
13	HOT WATER HEATER	2001	1,634	163	10	163		910	13
14	ELECTRIC BOOSTER HEATER	2001	1,639	164	10	164		888	14
15	BOILER REPAIR	2001	23,800	1,587	15	1,587		8,198	15
16	AIR CONDITIONER UNITS	2002	8,367	418	20	418		1,672	16
17	LIGHTING/C SECTION RENOVATION	2002	8,402	420	20	420		1,680	17
18	PARKING LOT IMPROVEMENTS	2003	4,800	320	15	320		1,040	18
19	ROOFING	1994	38,981	1,949	20	1,949		23,388	19
20	BOILERS (USED)	2004	2,529	169	15	169		492	20
21	CARPETING - ADMIN AREA	2004	1,564	156	10	156		312	21
22	WATER HEATER	2004	4,807	481	10	481		962	22
23	SPRINKLER SYSTEM	2004	103,957	10,396	10	10,396		20,792	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,572,471	\$ 165,767		\$ 165,767	\$	\$ 4,130,863	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: 12/1/05 Ending: 11/30/06

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 215,915	\$ 33,444	\$ 33,444	\$	VARIOUS	\$ 125,162	71
72	Current Year Purchases	20,213	1,861	1,861		VARIOUS	1,861	72
73	Fully Depreciated Assets	878,820				VARIOUS	878,820	73
74								74
75	TOTALS	\$ 1,114,948	\$ 35,305	\$ 35,305	\$		\$ 1,005,843	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENT TRANSPORT	FORD VAN 1996	1996	\$ 22,296	\$	\$	\$		\$ 22,296	76
77	MAINTENANCE	FORD TRUCK 1993	1993	19,169					19,169	77
78	RESIDENT TRANSPORT	CHEVY VAN W LIFTS 2003	2002	24,602	4,920	4,920			19,682	78
79										79
80	TOTALS			\$ 66,067	\$ 4,920	\$ 4,920	\$		\$ 61,147	80

E. Summary of Care-Related Assets

	1	Reference	2	Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)		\$ 6,753,486	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)		\$ 205,992	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)		\$ 205,992	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)		\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)		\$ 5,197,853	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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p><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)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			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 prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Exceptional Care Program									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.

Facility Name & ID Number VERMILION MANOR NURSING HOME# 0000786Report Period Beginning: 12/1/05

Ending:

11/30/06**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 11/30/06

(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	\$ 791,040	\$	1
2	Cash-Patient Deposits	24,396		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>115,000</u>)	1,247,368		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): <u>PROP. TAX RECEIVABLE</u>	653,400		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,716,204	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,572,471		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,181,015		16
17	Accumulated Depreciation (book methods)	(5,197,853)		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)	\$ 1,555,633	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,271,837	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 355,765	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,396		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	445,556		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	<u>DUE TO OTHER FUNDS</u>	1,802,777		36
37	<u>DEFERRED REVENUE</u>	653,400		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,281,894	\$	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)	\$ 3,281,894	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 989,943	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,271,837	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,715,928	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,715,928	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(725,985)	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)	\$ (725,985)	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)	\$ 989,943	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/05 Ending: 11/30/06

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	\$ 6,931,820	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,931,820	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	393	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)	\$ 393	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,262	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,262	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS - SEE ATTACHED	28,640	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 28,640	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,977,115	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,437,389	31
32	Health Care	4,440,474	32
33	General Administration	1,478,551	33
B. Capital Expense			
34	Ownership	205,996	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	140,690	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,703,100	40
41	Income before Income Taxes (line 30 minus line 40)**	(725,985)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (725,985)	43

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

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

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

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

Facility Name & ID Number VERMILION MANOR NURSING HOME

000786

Report Period Beginning:

12/1/05

Ending:

11/30/06

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

(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	1,670	1,835	\$ 38,741	\$ 21.11	1
2	Assistant Director of Nursing	1,863	2,130	51,778	24.31	2
3	Registered Nurses	28,310	30,381	670,665	22.08	3
4	Licensed Practical Nurses	45,510	49,126	882,674	17.97	4
5	CNAs & Orderlies	130,158	141,344	1,538,557	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,995	6,619	49,402	7.46	8
9	Activity Director	1,509	1,596	15,634	9.80	9
10	Activity Assistants	7,675	8,500	70,853	8.34	10
11	Social Service Workers	6,912	7,971	85,059	10.67	11
12	Dietician					12
13	Food Service Supervisor	7,920	8,688	84,693	9.75	13
14	Head Cook	9,567	10,381	97,943	9.43	14
15	Cook Helpers/Assistants	27,252	28,817	209,407	7.27	15
16	Dishwashers					16
17	Maintenance Workers	9,856	10,834	129,648	11.97	17
18	Housekeepers	14,822	16,105	124,041	7.70	18
19	Laundry	11,608	15,850	96,406	6.08	19
20	Administrator	2,032	2,128	63,129	29.67	20
21	Assistant Administrator	587	603	13,908	23.06	21
22	Other Administrative					22
23	Office Manager	2,091	2,300	36,126	15.71	23
24	Clerical	12,250	13,653	119,016	8.72	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	1,676	2,089	25,649	12.28	31
32	Other Health C: <u>Plan Coordinator</u>	3,648	4,150	79,731	19.21	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	332,911	365,100	\$ 4,483,060 *	\$ 12.28	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	\$ 21,741		35
36	Medical Director			36
37	Medical Records Consultant	1,680		37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,400		39
40	Physical Therapy Consultant	7,738		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>	3,630		46
47	<u>COMPUTER SUPPORT</u>	15,624		47
48				48
49	TOTAL (lines 35 - 48)	\$ 52,813		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	16	542	51
52	Certified Nurse Assistants/Aides			52
53	TOTAL (lines 50 - 52)	16	\$ 542	53

Facility Name & ID Number **VERMILION MANOR NURSING HOME**

0000786

Report Period Beginning: **12/1/05**

Ending: **11/30/06**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
JOAN DARR	ADMINISTRATOR		\$ 63,129	Workers' Compensation Insurance	\$ 97,414	IDPH License Fee	\$ 995		
				Unemployment Compensation Insurance	12,393	Advertising: Employee Recruitment	3,852		
				FICA Taxes	375,215	Health Care Worker Background Check			
				Employee Health Insurance	119,346	(Indicate # of checks performed <u>206</u>)	3,296		
				Employee Meals		DUES AND FEES	2,804		
				Illinois Municipal Retirement Fund (IMRF)*	452,416	PEER REVIEW	1,910		
				EMPLOYEE FRINGE BENEFITS	5,490				
				EMPLOYEE PHYSICALS	928				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 63,129	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,063,202		
TOTAL (List each licensed administrator separately.)				TOTAL (agree to Sch. V, line 20, col. 8)			\$ 12,857		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
							Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL			\$	TOTAL (agree to Sch. V, line 24, col. 8)	
TOTAL (Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
FR&R	MEDICAL CONSULTANT		\$ 3,630						
TOTAL (agree to Schedule V, line 19, column 3)			\$ 3,630						
TOTAL (If total legal fees exceed \$5,000, attach copy of invoices.)									

* Attach copy of IMRF notifications

**See instructions.

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? YES
If YES, give association name and amount. COUNTY NHA - \$1580
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 74,528 Line 10/2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 140,690
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? YES If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 8,325
- c. What percent of all travel expense relates to transportation of nurses and patients? 75%
- d. Have vehicle usage logs been maintained? YES
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? NO**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTON GUNDERSON LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NO If no, please explain. SEE ATTACHED
- (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 \$2500, 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.