



Facility Name & ID Number VERMILION MANOR NURSING HOME

# 0000786 Report Period Beginning: 12/1/06 Ending: 11/30/07

**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	138	Skilled (SNF)	138	48,434	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	36,699	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	233	TOTALS	233	85,133	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5		
		Medicaid Recipient	Private Pay	Other			Total
		8	SNF	4,073			736
9	SNF/PED					9	
10	ICF	34,802	6,837		41,639	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	38,875	7,573	7,078	53,526	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 62.87%

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

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

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 38 and days of care provided 6,675

Medicare Intermediary \_\_\_\_\_

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: N/A Fiscal Year: 12/01/06-11/30/07

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

STATE OF ILLINOIS

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/06 Ending: 11/30/07

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
<b>A. General Services</b>											
1	Dietary	449,368	51,438	27,266	528,072		528,072		528,072		1
2	Food Purchase		331,789		331,789		331,789		331,789		2
3	Housekeeping	119,154	24,845		143,999		143,999		143,999		3
4	Laundry	96,844	14,718		111,562		111,562		111,562		4
5	Heat and Other Utilities			216,120	216,120	(381)	215,739	(13,303)	202,436		5
6	Maintenance	135,148	24,409	43,996	203,553		203,553		203,553		6
7	Other (specify):* WASTE DISPOSAL			49,328	49,328		49,328		49,328		7
8	<b>TOTAL General Services</b>	<b>800,514</b>	<b>447,199</b>	<b>336,710</b>	<b>1,584,423</b>	<b>(381)</b>	<b>1,584,042</b>	<b>(13,303)</b>	<b>1,570,739</b>		<b>8</b>
<b>B. Health Care and Programs</b>											
9	Medical Director			24,000	24,000	(24,000)					9
10	Nursing and Medical Records	3,180,268	626,350	59,080	3,865,698		3,865,698		3,865,698		10
10a	Therapy			499,228	499,228		499,228		499,228		10a
11	Activities	102,636	390		103,026		103,026		103,026		11
12	Social Services	116,325	855		117,180		117,180		117,180		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* PLAN COORDINAT	88,593			88,593		88,593		88,593		15
16	<b>TOTAL Health Care and Programs</b>	<b>3,487,822</b>	<b>627,595</b>	<b>582,308</b>	<b>4,697,725</b>	<b>(24,000)</b>	<b>4,673,725</b>		<b>4,673,725</b>		<b>16</b>
<b>C. General Administration</b>											
17	Administrative	68,300		1,201,826	1,270,126		1,270,126		1,270,126		17
18	Directors Fees										18
19	Professional Services			3,871	3,871		3,871		3,871		19
20	Dues, Fees, Subscriptions & Promotions			14,585	14,585		14,585		14,585		20
21	Clerical & General Office Expenses	233,600	18,168	36,367	288,135		288,135		288,135		21
22	Employee Benefits & Payroll Taxes			907,440	907,440		907,440		907,440		22
23	Inservice Training & Education			1,560	1,560		1,560		1,560		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,095	8,095		8,095		8,095		25
26	Insurance-Prop.Liab.Malpractice			59,230	59,230		59,230		59,230		26
27	Other (specify):* BAD DEBT			239,154	239,154		239,154	(239,154)			27
28	<b>TOTAL General Administration</b>	<b>301,900</b>	<b>18,168</b>	<b>2,472,128</b>	<b>2,792,196</b>		<b>2,792,196</b>	<b>(239,154)</b>	<b>2,553,042</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>4,590,236</b>	<b>1,092,962</b>	<b>3,391,146</b>	<b>9,074,344</b>	<b>(24,381)</b>	<b>9,049,963</b>	<b>(252,457)</b>	<b>8,797,506</b>		<b>29</b>

\*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: 12/1/06 Ending: 11/30/07

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			205,462	205,462		205,462		205,462			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			20,916	20,916		20,916		20,916			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			226,378	226,378		226,378		226,378			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
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			129,275	129,275		129,275		129,275			42
43	Other (specify):* <b>EXCEPTIONAL CARE EXPENSES</b>											43
44	<b>TOTAL Special Cost Centers</b>			129,275	129,275	24,381	153,656		153,656			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,590,236	1,092,962	3,746,799	9,429,997		9,429,997	(252,457)	9,177,540			45

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

**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	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(13,303)	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	(239,154)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (252,457)		\$	30

<b>BHF USE ONLY</b>						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (252,457)		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	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$ 381		47

STATE OF ILLINOIS  
 VERMILION MANOR NURSING HOME

ID# 0000786  
 Report Period Beginning: 12/1/06  
 Ending: 11/30/07

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	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	<b>Total</b>	0	49

STATE OF ILLINOIS

Summary A

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

# **0000786**

Report Period Beginning:

12/1/06

Ending:

11/30/07

**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)	
<b>A. General Services</b>														
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	(13,303)	0	0	0	0	0	0	0	0	0	0	(13,303)	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	<b>TOTAL General Services</b>	<b>(13,303)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,303)</b>	<b>8</b>
<b>B. Health Care and Programs</b>														
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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
<b>C. General Administration</b>														
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):*	(99,101)	0	0	0	0	0	0	0	0	0	0	(99,101)	27
28	<b>TOTAL General Administration</b>	<b>(99,101)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(99,101)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(112,404)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(112,404)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/06 Ending: 11/30/07

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

	Capital Expense	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)
	<b>D. Ownership</b>												
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	<b>TOTAL Ownership</b>	0	0	0	0	0	0	0	0	0	0	0	0 37
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
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	<b>TOTAL Special Cost Centers</b>	0	0	0	0	0	0	0	0	0	0	0	0 44
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(112,404)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(112,404) 45</b>

Facility Name & ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning: 12/1/06

Ending: 11/30/07

**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		\$			\$	\$	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: 12/1/06 Ending: 11/30/07

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/06 Ending: 11/30/07

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

Facility Name & ID Number **VERMILION MANOR NURSING HOME** # **0000786** Report Period Beginning: **12/1/06** Ending: **11/30/07**

**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	
						Original	Balance					
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										
<b>A. Directly Facility Related</b>												
<b>Long-Term</b>												
1	<b>OPERATING LOAN FROM</b>					\$	\$			\$	1	
2	<b>VERMILION COUNTY</b>										2	
3	<b>GENERAL FUND</b>	X		<b>OPERATING CASH FLOW</b>	<b>\$26,038.00</b>	<b>2/15/07</b>	<b>888,593</b>	<b>675,101</b>	<b>2/15/10</b>	<b>3.5000</b>	<b>20,915</b>	3
4											4	
5											5	
<b>Working Capital</b>												
6											6	
7											7	
8											8	
9	<b>TOTAL Facility Related</b>				<b>\$26,038.00</b>		<b>\$ 888,593</b>	<b>\$ 675,101</b>			<b>\$ 20,915</b>	9
<b>B. Non-Facility Related*</b>												
10											10	
11											11	
12											12	
13											13	
14	<b>TOTAL Non-Facility Related</b>						<b>\$</b>	<b>\$</b>			<b>\$</b>	14
15	<b>TOTALS (line 9+line14)</b>						<b>\$ 888,593</b>	<b>\$ 675,101</b>			<b>\$ 20,915</b>	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 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: **12/1/06** Ending: **11/30/07**

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

**B. Real Estate Taxes**

<p><b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2006 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 2007 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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ 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. <b>TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$ 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:	2002	N/A	8
	2003	N/A	9
	2004	N/A	10
	2005	N/A	11
	2006	N/A	12
	<b>FOR BHF USE ONLY</b>		
	13	FROM R. E. TAX STATEMENT FOR 2006 \$	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.**

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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,

**2006 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 Costs**

Enter the tax index number and real estate tax assessed for 2006 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 2006.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ _____	\$ _____

**B. Real Estate Tax Cost Allocation:**

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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

**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.

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 ground (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)

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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	<b>TOTALS</b>			\$	3

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning:

12/1/06

Ending:

11/30/07

## 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		
Bed*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	138	1974	1974	\$ 2,290,108	\$ 57,253	40	\$ 57,253	\$	\$ 1,937,039	4
5	95	1979	1979	1,961,500	49,038	40	49,038		1,392,876	5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	PARKING LOT/GARAGE		1980	16,200		10			16,200	9
10	CONSTRUCTION		1980	92,111	2,303	40	2,303		64,480	10
11	FINAL CONSTRUCTION		1981	6,000	150	40	150		4,050	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		2,762	23
24	CERAMIC TILES		1988	6,872	344	20	344		6,617	24
25	TIME CLOCK/COMPUTER		1988	2,030	101	20	101		1,945	25
26	INCREMENTAL CONDITIONER		1988	17,116	856	20	856		16,260	26
27	WATER HEATER		1988	1,457		15			1,457	27
28	400 AMP LINE		1988	3,400	170	20	170		3,329	28
29	CANOPY REPAIR		1988	12,075	604	20	604		11,773	29
30	DOOR O MATIC		1989	1,763	88	20	88		1,645	30
31	AIR CONDITIONER		1989	146,368	7,318	20	7,318		127,823	31
32	HOT WATER STORAGE TANK		1990	4,589	229	20	229		4,054	32
33	CAPITAL IMPROVEMENT		1990	18,139	907	20	907		16,098	33
34	AIR CONDITIONER UNITS		1991	21,470	1,074	20	1,074		18,891	34
35	PUMPS		1991	1,700	85	20	85		1,424	35
36	AIR CONDITIONER		1991	9,217	461	20	461		7,566	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

## STATE OF ILLINOIS

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning:

12/1/06

Ending:

Page 12A

11/30/07

## 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	\$	\$ 3,515	37
38	PLUMBING	1992	7,162	358	20	358		5,759	38
39	AIR HANDLER/CORNER GUARDS	1991	4,028	201	20	201		3,224	39
40	ROOF REPAIR	1991	10,500	525	20	525		8,838	40
41	FIRE HYDRANT	1991	2,185	109	20	109		1,839	41
42	GENERATOR	1992	70,808	3,540	20	3,540		55,394	42
43	PLUMBING	1992	62,884	3,144	20	3,144		49,146	43
44	LIGHT FIXTURES	1992	1,395	70	20	70		1,081	44
45	AIR CONDITIONERS	1992	24,201	1,210	20	1,210		18,610	45
46	ROOF REPAIR	1993	38,982	1,949	20	1,949		28,166	46
47	WALK IN FREEZER	1993	11,400	570	20	570		8,360	47
48	MASTER STATION IMPROVEMENTS	1993	3,215	214	20	214		3,107	48
49	SMOKING ROOM	1993	6,511	325	20	325		4,693	49
50	LOUNGE WALL	1993	1,004	50	20	50		715	50
51	KITCHEN IMPROVEMENTS	1993	9,952	498	20	498		7,111	51
52	80 GALLON WATER HEATER	1994	5,987	299	20	299		4,091	52
53	ACTIVATOR PARTS	1994	1,190	59	20	59		813	53
54	DAMPERS	1994	3,082	154	20	154		2,068	54
55	CALL SYSTEM	1994	3,427	171	20	171		2,227	55
56	GARAGE	1994	13,254	663	20	663		8,615	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		390	60
61	EXHAUST SYSTEM	1996	5,347		10			5,347	61
62	CONCRETE WORK - FRONT ENTRANCE	1996	1,050	70	15	70		799	62
63	CONCRETE WORK - DRIVEWAYS	1996	10,170	678	15	678		7,684	63
64	CANOPY	1996	19,619	1,308	15	1,308		14,605	64
65	TILE REPLACEMENT	1996	1,129		10			1,129	65
66	ROOF REPAIR	1997	30,645	1,532	20	1,532		15,960	66
67	AIR CONDITIONER UNITS	1997	15,320	766	20	766		7,853	67
68	REPAIR DRIVE	1997	2,900	193	10	193		2,900	68
69	WATER HEATER	1998	6,200	620	10	620		5,735	69
70	TOTAL (lines 4 thru 69)		\$ 5,224,536	\$ 140,649		\$ 140,649	\$	\$ 4,147,112	70

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

STATE OF ILLINOIS

Facility Name & ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning:

12/1/06

Ending:

Page 12B

11/30/07

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	\$ 140,649		\$ 140,649		\$ 4,147,112		1
2	CAPITAL IMPROVEMENT	1998 1,013	101	10	101		911		2
3	ROOF	1998 21,809	2,181	10	2,181		19,810		3
4	AIR CONDITIONER UNITS	1998 9,160	458	20	458		4,160		4
5	AIR CONDITIONER UNITS	1998 8,580	429	20	429		3,861		5
6	NEW ROOF	1999 22,973	1,149	20	1,149		9,572		6
7	AIR CONDITIONER UNITS	1999 49,921	2,496	20	2,496		20,800		7
8	CANOPY REPAIR	1999 7,630	382	20	382		3,147		8
9	GENERATOR	2000 7,951	398	20	398		3,015		9
10	WATER HEATER	2000 8,368	418	20	418		3,068		10
11	CONDENSER	2000 2,350	118	20	118		852		11
12	CANOPY REPAIR	2001 7,700	513	15	513		3,508		12
13	HOT WATER HEATER	2001 1,634	163	10	163		1,076		13
14	ELECTRIC BOOSTER HEATER	2001 1,639	164	10	164		1,051		14
15	BOILER REPAIR	2001 23,800	1,587	15	1,587		9,785		15
16	AIR CONDITIONER UNITS	2002 8,367	418	20	418		2,092		16
17	LIGHTING/C SECTION RENOVATION	2002 8,402	420	20	420		2,101		17
18	PARKING LOT IMPROVEMENTS	2003 4,800	320	15	320		1,360		18
19	ROOFING	1994 38,981	1,949	20	1,949		25,338		19
20	BOILERS (USED)	2004 2,529	168	15	168		660		20
21	CARPETING - ADMIN AREA	2004 1,564	156	10	156		469		21
22	WATER HEATER	2004 4,807	483	10	483		1,442		22
23	SPRINKLER SYSTEM	2004 103,957	10,396	10	10,396		31,187		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	\$ 165,516		\$ 165,516	\$	\$ 4,296,377		34

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

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	\$ 837,240	\$ 34,554	\$ 34,554	\$	VARIOUS	\$ 762,689	71
72	Current Year Purchases	9,232	472	472			472	72
73	Fully Depreciated Assets	277,708					277,708	73
74								74
75	TOTALS	\$ 1,124,180	\$ 35,026	\$ 35,026	\$		\$ 1,040,869	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			24,602	78
79										79
80	TOTALS			\$ 66,067	\$ 4,920	\$ 4,920	\$		\$ 66,067	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$ 6,762,718 81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 205,462 82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 205,462 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)	\$ 5,403,313 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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:  
 Beginning \_\_\_\_\_  
 Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>      </u> /2008	\$ <u>      </u>
13.	<u>      </u> /2009	\$ <u>      </u>
14.	<u>      </u> /2010	\$ <u>      </u>

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	<b>TOTAL</b>		\$	\$	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.

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <b>CLASSROOM PORTION:</b></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. <b>CLINICAL PORTION:</b></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			Total
		1 Drop-outs	2 Completed	3 Contract	
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	<b>TOTALS</b>	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (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.

**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)	
<b>TOTAL TRAINED</b>	

- (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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	LINE 39(8)	52 visits			24,000		52	24,000	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$		\$ 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

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Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

# 0000786

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/07

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 678,525	\$	1
2	Cash-Patient Deposits	23,968		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 115,000 )	1,185,541		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): PROP. TAX RECEIVABLE	692,663		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,580,697	\$	10
<b>B. Long-Term Assets</b>				
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	1,190,247		16
17	Accumulated Depreciation (book methods)	(5,403,313)		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	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 1,359,405	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 3,940,102	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 558,957	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	23,968		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	108,606		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
<b>Other Current Liabilities(specify):</b>				
36	<u>DUE TO OTHER FUNDS</u>	1,588,989		36
37	<u>DEFERRED REVENUE</u>	692,663		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,973,183	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,973,183	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 966,919	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 3,940,102	\$	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 838,169	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 838,169	6
<b>A. Additions (deductions):</b>			
7	NET Income (Loss) (from page 19, line 43)	128,750	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)	\$ 128,750	17
<b>B. Transfers (Itemize):</b>			
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)	\$ 966,919	24 *

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

## STATE OF ILLINOIS

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

# 0000786

Report Period Beginning: 12/1/06

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**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,490,621	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 9,490,621	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
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	38	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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 38	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	52,120	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 52,120	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>MISCELLANEOUS - SEE ATTACHED</b>	15,968	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 15,968	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 9,558,747	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,584,423	31
32	Health Care	4,697,725	32
33	General Administration	2,792,196	33
<b>B. Capital Expense</b>			
34	Ownership	205,462	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers		35
36	Provider Participation Fee	129,275	36
<b>D. Other Expenses (specify):</b>			
37	<b>INTEREST EXPENSE</b>	20,916	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 9,429,997	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	128,750	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 128,750	43

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

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

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

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

Facility Name &amp; ID Number VERMILION MANOR NURSING HOME

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## 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	1,746	2,029	\$ 52,705	\$ 25.98	1
2	Assistant Director of Nursing	1,189	1,447	35,742	24.70	2
3	Registered Nurses	19,849	21,593	508,601	23.55	3
4	Licensed Practical Nurses	43,710	48,094	834,400	17.35	4
5	CNAs & Orderlies	138,466	153,565	1,674,032	10.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,497	5,089	49,433	9.71	8
9	Activity Director	1,728	2,047	17,187	8.40	9
10	Activity Assistants	8,814	9,643	85,449	8.86	10
11	Social Service Workers	7,545	9,132	116,325	12.74	11
12	Dietician					12
13	Food Service Supervisor	6,899	7,996	85,901	10.74	13
14	Head Cook	10,350	11,486	112,161	9.77	14
15	Cook Helpers/Assistants	34,431	37,076	251,306	6.78	15
16	Dishwashers					16
17	Maintenance Workers	7,468	8,343	135,148	16.20	17
18	Housekeepers	15,433	16,923	119,154	7.04	18
19	Laundry	11,143	12,406	96,844	7.81	19
20	Administrator	1,904	2,056	68,300	33.22	20
21	Assistant Administrator	1,501	1,776	57,827	32.56	21
22	Other Administrative					22
23	Office Manager	2,053	2,350	37,974	16.16	23
24	Clerical	14,011	15,626	137,799	8.82	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	1,657	2,024	25,355	12.53	31
32	Other Health Care(specify)	3,869	4,555	88,593	19.45	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	338,263	375,256	\$ 4,590,236 *	\$ 12.23	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	\$ 27,266		35
36	Medical Director			36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,600		39
40	Physical Therapy Consultant	2,805		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	3,871		46
47	COMPUTER SUPPORT	12,949		47
48				48
49	TOTAL (lines 35 - 48)	\$ 49,491		49

## C. CONTRACT NURSES

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





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**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 - \$1,360
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 63,020 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 NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
- 
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 129,275  
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 benefit: 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. \$ 576
- 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: 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 \$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.