

		FOR BHF USE				

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2008
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2008)

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.

<p>I. IDPH License ID Number: <u>0000786</u></p> <p>Facility Name: <u>VERMILION MANOR NURSING HOME</u></p> <p>Address: <u>14792 CATLIN-TILTON ROAD</u> <u>DANVILLE</u> <u>61834</u> <small>Number City Zip Code</small></p> <p>County: <u>VERMILION</u></p> <p>Telephone Number: <u>217-443-6430</u> Fax # <u>217-443-1558</u></p> <p>HFS ID Number: <u>37-6002224-001</u></p> <p>Date of Initial License for Current Owners: <u>01/01/1974</u></p> <p>Type of Ownership:</p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </td> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____ </td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>JOAN DARR</u> Telephone Number: <u>217-443-6430</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____	<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/1/07</u> to <u>11/30/08</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20%; padding: 2px;">Officer or Administrator of Provider</td> <td style="padding: 2px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Type or Print Name) <u>JOAN DARR</u></td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Title) <u>ADMINISTRATOR</u></td> </tr> <tr> <td style="padding: 2px;">Paid Preparer</td> <td style="padding: 2px;">(Signed) _____ (Date) _____</td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Print Name and Title) <u>SEE ATTACHED ACCOUNTANT'S REPORT</u></td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Firm Name & Address) <u>CLIFTON GUNDERSON LLP</u> <u>2 E MAIN STREET, SUITE 120, DANVILLE, IL 61832</u></td> </tr> <tr> <td style="padding: 2px;"></td> <td style="padding: 2px;">(Telephone) <u>217-442-1643</u> Fax # <u>217-443-5470</u></td> </tr> </table> <p style="font-size: small; margin-top: 5px;"> 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 </p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____		(Type or Print Name) <u>JOAN DARR</u>		(Title) <u>ADMINISTRATOR</u>	Paid Preparer	(Signed) _____ (Date) _____		(Print Name and Title) <u>SEE ATTACHED ACCOUNTANT'S REPORT</u>		(Firm Name & Address) <u>CLIFTON GUNDERSON LLP</u> <u>2 E MAIN STREET, SUITE 120, DANVILLE, IL 61832</u>		(Telephone) <u>217-442-1643</u> Fax # <u>217-443-5470</u>
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	<input checked="" type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____																
Officer or Administrator of Provider	(Signed) _____ (Date) _____																	
	(Type or Print Name) <u>JOAN DARR</u>																	
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	(Telephone) <u>217-442-1643</u> Fax # <u>217-443-5470</u>																	

Facility Name & ID Number VERMILION MANOR NURSING HOME# 0000786 Report Period Beginning: 12/1/07 Ending: 11/30/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	142	Skilled (SNF)	142	51,922	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	34,770	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	237	86,692	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 Patient Days by Level of Care and Primary Source of Payment			5		
		Medicaid Recipient	Private Pay	Other			Total
		8	SNF	3,305			958
9	SNF/PED					9	
10	ICF	34,664	5,703		40,367	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	37,969	6,661	7,518	52,148	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.15%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)
NAF. 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 01/01/1974J. 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 7,148

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: NA Fiscal Year: 12/1/07 - 11/30/08

* 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: 12/1/07 Ending: 11/30/08

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
A. General Services											
1	Dietary	476,724	56,964	22,271	555,959		555,959	555,959			1
2	Food Purchase		404,011		404,011		404,011	404,011			2
3	Housekeeping	145,723	28,068		173,791		173,791	173,791			3
4	Laundry	99,725	16,611		116,336		116,336	116,336			4
5	Heat and Other Utilities			226,368	226,368	(413)	225,955	209,838	(16,117)		5
6	Maintenance	140,102	30,156	64,054	234,312		234,312	234,312			6
7	Other (specify):* WASTE DISPOSAL			63,968	63,968		63,968	63,968			7
8	TOTAL General Services	862,274	535,810	376,661	1,774,745	(413)	1,774,332	1,758,215	(16,117)		8
B. Health Care and Programs											
9	Medical Director			24,000	24,000	(24,000)					9
10	Nursing and Medical Records	3,087,423	761,582	49,912	3,898,917		3,898,917	3,898,917			10
10a	Therapy			598,673	598,673		598,673	598,673			10a
11	Activities	83,379		485	83,864		83,864	83,864			11
12	Social Services	115,746		458	116,204		116,204	116,204			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* PLAN COORDINAT	78,901			78,901		78,901	78,901			15
16	TOTAL Health Care and Programs	3,365,449	761,582	673,528	4,800,559	(24,000)	4,776,559	4,776,559			16
C. General Administration											
17	Administrative	71,388			71,388		71,388	71,388			17
18	Directors Fees										18
19	Professional Services			4,465	4,465		4,465	4,465			19
20	Dues, Fees, Subscriptions & Promotions			7,097	7,097		7,097	7,097			20
21	Clerical & General Office Expenses	221,385	21,882	45,772	289,039		289,039	289,039			21
22	Employee Benefits & Payroll Taxes			974,437	974,437		974,437	974,437			22
23	Inservice Training & Education			2,602	2,602		2,602	2,602			23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			11,555	11,555		11,555	11,555			25
26	Insurance-Prop.Liab.Malpractice			65,630	65,630		65,630	65,630			26
27	Other (specify):* BAD DEBT EXPENSE			130,526	130,526		130,526	(130,526)			27
28	TOTAL General Administration	292,773	21,882	1,242,084	1,556,739		1,556,739	1,426,213	(130,526)		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,520,496	1,319,274	2,292,273	8,132,043	(24,413)	8,107,630	7,960,987	(146,643)		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: 12/1/07 Ending: 11/30/08

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	
	D. Ownership											
30	Depreciation			195,476	195,476		195,476		195,476			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,950	18,950		18,950		18,950			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			214,426	214,426		214,426		214,426			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					413	413		413			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,138	129,138		129,138		129,138			42
43	Other (specify):* Internal Co Service			2,025,970	2,025,970		2,025,970	(2,025,970)				43
44	TOTAL Special Cost Centers			2,155,108	2,155,108	24,413	2,179,521	(2,025,970)	153,551			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,520,496	1,319,274	4,661,807	10,501,577		10,501,577	(2,172,613)	8,328,964			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: 12/1/07

Ending: 11/30/08

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(16,117)	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	(130,526)	V27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax				27
28	CNA Training for Non-Employees				28
29	Yellow Page Advertising				29
29	Other-Attach Schedule	(2,025,970)	V17		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,172,613)		\$	30

BHF USE ONLY							
48		49	50	51	52		

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,172,613)		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			413	V5(3)	41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 413		47

STATE OF ILLINOIS
 VERMILION MANOR NURSING HOME

ID# 0000786
 Report Period Beginning: 12/1/07
 Ending: 11/30/08

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
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
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24				24
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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	0		49

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning: 12/1/07

Ending: 11/30/08

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
NA		NA		VERMILION COUNTY	DANVILLE	COUNTY GOVERNMENT

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

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

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/07 Ending: 11/30/08

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	NA								\$	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: 12/1/07 Ending: 11/30/08

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	TOTALS				\$	\$		\$	25

Facility Name & ID Number **VERMILION MANOR NURSING HOME** # **0000786** Report Period Beginning: **12/1/07** Ending: **11/30/08**

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									
	A. Directly Facility Related											
	Long-Term											
1	OPERATING LOAN FROM						\$	\$			\$	1
2	VERMILION COUNTY											2
3	GENERAL FUND	X		OPERATING CASH FLOW	\$26,038.00	2/15/07	888,593	381,600	2/15/2010	3.5000	18,950	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$26,038.00		\$ 888,593	\$ 381,600			\$ 18,950	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 888,593	\$ 381,600			\$ 18,950	15

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

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

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

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

0000786 Report Period Beginning: **12/1/07** Ending: **11/30/08**

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

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1.	Real Estate Tax accrual used on 2007 report.		\$ NA	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.)		\$ NA	2
3.	Under or (over) accrual (line 2 minus line 1).		\$ NA	3
4.	Real Estate Tax accrual used for 2008 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ NA	4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ NA	5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ NA	6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ NA	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2003	NA	8	
	2004	NA	9	
	2005	NA	10	
	2006	NA	11	
	2007	NA	12	
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2007	\$	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: 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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,

2007 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 2007 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 2007.

(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 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008

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)

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:

12/1/07

Ending:

11/30/08

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		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	142	1974	1974	\$ 2,290,108	\$ 57,253	40	\$ 57,253	\$	\$ 1,994,291	4
5	95	1979	1979	1,961,500	49,038	40	49,038		1,441,913	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		66,783	10
11	FINAL CONSTRUCTION		1981	6,000	150	40	150		4,200	11
12	PUMP		1982	9,414		10			9,414	12
13	ROOF		1982	40,042		10			40,042	13
14	ROOF		1983	39,569		10			39,569	14
15	ROOF		1984	52,663		10			52,663	15
16	WATER HEATER		1985	27,463		10			27,463	16
17	WATER LINE		1985	5,290		10			5,290	17
18	DRIVEWAY		1985	4,200		10			4,200	18
19	LINT CATCHER		1986	5,981		10			5,981	19
20	PARKING LOT/GARAGE		1986	26,927		10			26,927	20
21	ROOF/DUCT WORK		1986	6,114		10			6,114	21
22	FENCE		1986	609		10			609	22
23	400 AMP LINE		1988	3,400	71	20	71		3,400	23
24	PVC RUB RAILS		1988	2,821	59	20	59		2,821	24
25	CANOPY REPAIR		1988	12,075	302	20	302		12,075	25
26	REPLATE CERAMIC TILE		1988	2,485	72	20	72		2,485	26
27	TIME CLOCK/COMPUTER		1988	2,030	85	20	85		2,030	27
28	REPAIR CERAMIC TILE		1988	4,387	183	20	183		4,387	28
29	CONDITIONER		1988	17,116	856	15	856		17,116	29
30	WATER METER		1988	1,457		20			1,457	30
31	BUILDING IMPROVEMENTS		1989	334	17	20	17		332	31
32	DOOR O MATIC		1989	1,763	88	20	88		1,733	32
33	AIR CONDITIONERS		1990	146,034	7,302	20	7,302		134,809	33
34	FIRE RATED DOOR		1990	358	18	20	18		339	34
35	BUILDING IMPROVEMENTS		1990	163	8	20	8		154	35
36	WINDOW		1990	198	10	20	10		186	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

Page 12A

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	AIR CONDITIONER UNITS	1990	\$ 14,149	\$ 707	20	\$ 707	\$	\$ 13,206	37
38	CAPITAL IMPROVEMENTS	1990	18,139	907	20	907		17,005	38
39	HOT WATER STORAGE TANK	1990	4,589	229	20	229		4,283	39
40	AIR CONDITIONER	1990	6,602	330	20	330		6,079	40
41	ROOF REPAIR	1991	10,500	525	20	525		9,363	41
42	FIRE HYDRANT	1991	2,185	109	20	109		1,948	42
43	PUMPS	1991	1,700	85	20	85		1,509	43
44	AIR CONDITIONERS	1991	9,217	461	20	461		8,027	44
45	LOCK ON SERVICE DOORS	1991	55	3	20	3		47	45
46	CAPITAL IMPROVEMENTS	1991	1,370	68	20	68		1,176	46
47	FIRE DOOR AND SENSORS	1991	1,586	79	20	79		1,361	47
48	SHEETROCK AND BUILDING MATERIALS	1991	143	7	20	7		123	48
49	SIGNS	1991	122	6	20	6		104	49
50	LIGHT FIXTURES	1991	180	9	20	9		154	50
51	CAPITAL IMPROVEMENTS	1991	899	45	20	45		768	51
52	PLUMBING	1991	7,162	358	20	358		6,117	52
53	CORNER GUARDS	1991	367	18	20	18		313	53
54	AIR HANDLER	1991	3,661	183	20	183		3,112	54
55	CAPITAL IMPROVEMENTS	1992	4,880	244	20	244		4,107	55
56	GENERATOR	1992	19,380	969	20	969		16,231	56
57	PLUMBING	1992	11,543	577	20	577		9,667	57
58	PLUMBING	1992	21,222	1,061	20	1,061		17,685	58
59	GENERATOR	1992	46,548	2,327	20	2,327		38,596	59
60	PLUMBING	1992	21,293	1,065	20	1,065		17,656	60
61	CAPITAL IMPROVEMENTS	1992	11,616	581	20	581		9,632	61
62	LIGHT FIXTURES	1992	1,395	70	20	70		1,151	62
63	PLUMBING	1992	8,826	441	20	441		7,282	63
64	AIR CONDITIONER	1992	2,765	138	20	138		2,247	64
65	AIR CONDITIONER	1992	5,368	268	20	268		4,362	65
66	CAPITAL IMPROVEMENTS	1992	4,452	223	20	223		3,580	66
67	REROOFING	1993	4,000	200	20	200		3,150	67
68	WALK IN FREEZER	1993	11,400	570	20	570		8,930	68
69	CALL MASTER STATION	1993	3,215	107	15	107		3,215	69
70	TOTAL (lines 4 thru 69)		\$ 5,039,341	\$ 130,785		\$ 130,785	\$	\$ 4,147,169	70

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

STATE OF ILLINOIS

Page 12B

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/07

Ending:

11/30/08

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	\$ 5,039,341	\$ 130,785		\$ 130,785		\$ 4,147,169		1
2	CAPITAL IMPROVEMENTS	1993 4,968	248	20	248		3,850		2
3	ROOFING	1993 32,207	1,610	20	1,610		24,826		3
4	ROOFING	1993 2,775	139	20	139		2,139		4
5	SMOKING ROOM	1993 6,511	326	20	326		5,019		5
6	A LOUNGE WALL	1993 1,004	50	20	50		766		6
7	KITCHEN	1993 4,984	249	20	249		3,759		7
8	HOT WATER HEATER	1994 5,987	299	20	299		4,390		8
9	ACTIVATOR	1994 1,190	59	20	59		872		9
10	LABOT DAMPERS	1994 3,082	154	20	154		2,221		10
11	CALL SYSTEM	1994 3,427	171	20	171		2,399		11
12	GARAGE	1994 4,050	203	20	203		2,835		12
13	ROOFING	1994 38,981	1,949	20	1,949		27,287		13
14	DOOR OPENER	1994 2,849	142	20	142		1,994		14
15	CAPITAL IMPROVEMENTS	1994 4,952	248	20	248		3,466		15
16	GARAGE	1994 1,403	70	20	70		982		16
17	BOOSTER HEATER	1995 4,320		10			4,320		17
18	CALL LIGHT SYSTEM	1995 3,577		10			3,577		18
19	FOLDING PARTITION	1995 4,880		10			4,880		19
20	REWIRE GARAGE	1995 650	33	20	33		423		20
21	EXHAUST SYSTEM	1996 5,346		10			5,346		21
22	FRONT ENTRANCE	1996 1,050	70	15	70		869		22
23	DRIVEWAY	1996 10,170	678	15	678		8,362		23
24	CANOPY	1996 19,619	1,308	15	1,308		15,913		24
25	TILE REPLACEMENT	1996 1,129		10			1,128		25
26	ROOF REPAIR	1996 30,645	1,532	20	1,532		17,493		26
27	REPAIR DRIVE	1997 2,900		10			2,900		27
28	AIR CONDITIONER UNITS	1997 15,322	766	20	766		8,619		28
29	WATER HEATER	1998 6,200	465	10	465		6,200		29
30	ROOF	1998 21,809	1,999	10	1,999		21,809		30
31	AIR CONDITIONER UNITS	1998 9,160	458	20	458		4,618		31
32	CAPITAL IMPROVEMENTS	1998 1,012	101	10	101		1,013		32
33	AIR CONDITIONER UNITS	1998 8,580	429	20	429		4,290		33
34	TOTAL (lines 1 thru 33)	\$ 5,304,080	\$ 144,541		\$ 144,541		\$ 4,345,734		34

**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:

12/1/07

Ending:

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11/30/08

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 12B, Carried Forward	\$ 5,304,080	\$ 144,541		\$ 144,541		\$ 4,345,734		1
2	AIR CONDITIONER UNITS	1999 49,921	2,496	20	2,496		23,297		2
3	ROOF	1999 22,973	1,149	20	1,149		10,721		3
4	CANOPY REPAIR	1999 7,630	382	20	382		3,529		4
5	GENERATOR	2000 7,951	398	20	398		3,412		5
6	WATER HEATER	2000 8,368	418	20	418		3,487		6
7	CONDENSER	2000 2,350	118	20	118		969		7
8	CANOPY REPAIR	2001 7,700	513	15	513		4,021		8
9	HOT WATER HEATER	2001 1,634	163	10	163		1,239		9
10	ELECTRIC BOOSTER HEATER	2001 1,639	164	10	164		1,215		10
11	BOILER REPAIR	2001 23,800	1,587	15	1,587		11,371		11
12	AIR CONDITIONER UNITS	2001 8,367	418	20	418		2,510		12
13	LIGHTING RENOVATION	2002 8,402	420	20	420		2,521		13
14	PARKING LOT IMPROVEMENTS	2003 4,800	320	15	320		1,680		14
15	BOILERS	2004 2,529	169	15	169		829		15
16	CARPETING	2004 1,564	157	10	157		626		16
17	WATER HEATER	2004 4,807	481	10	481		1,923		17
18	SPRINKLER SYSTEM	2004 103,956	10,396	10	10,396		41,583		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	TOTAL (lines 1 thru 33)	\$ 5,572,471	\$ 164,290		\$ 164,290		\$ 4,460,667		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	\$ 824,498	\$ 29,182	\$ 29,182	\$	VARIOUS	\$ 770,369	71
72	Current Year Purchases	13,960	2,004	2,004		5	2,004	72
73	Fully Depreciated Assets	299,682					299,682	73
74								74
75	TOTALS	\$ 1,138,140	\$ 31,186	\$ 31,186	\$		\$ 1,072,055	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 2002	2002	24,602					24,602	78
79										79
80	TOTALS			\$ 66,067	\$	\$	\$		\$ 66,067	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)	\$	6,776,678	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	195,476	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	195,476	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)	\$	5,598,789	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: NA
 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

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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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	TOTAL		\$	\$	21

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		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	TOTALS	\$	\$	\$	\$
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)	
TOTAL TRAINED	

- (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	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$		\$ 24,000	\$	52	\$ 24,000	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning: 12/1/07

Ending:

11/30/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/08

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 1,618,184	\$	1
2	Cash-Patient Deposits	25,201		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000)	1,478,562		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): PROPERTY TAX RECEIVABL	692,778		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,814,725	\$	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	1,204,207		16
17	Accumulated Depreciation (book methods)	(5,598,789)		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)	\$ 1,177,889	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,992,614	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 846,053	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	25,201		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	181,999		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	DUE TO OTHER FUNDS	1,287,564		36
37	DEFERRED REVENUE	692,778		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,033,595	\$	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)	\$ 3,033,595	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,959,019	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,992,614	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 966,919	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 966,919	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	992,100	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)	\$ 992,100	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)	\$ 1,959,019	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number VERMILION MANOR NURSING HOME

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Report Period Beginning: 12/1/07

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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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 10,660,999	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,660,999	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	134,992	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 134,992	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS - SEE ATTACHED	12,042	28
28a	PROPERTY TAX REVENUE	685,644	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 697,686	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,493,677	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,754,534	31
32	Health Care	4,820,770	32
33	General Administration	3,582,709	33
B. Capital Expense			
34	Ownership	214,426	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	129,138	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,501,577	40
41	Income before Income Taxes (line 30 minus line 40)**	992,100	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 992,100	43

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

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

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

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

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

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Ending: 11/30/08

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	2,213	2,504	\$ 64,839	\$ 25.89	1
2	Assistant Director of Nursing	1,911	2,106	47,611	22.61	2
3	Registered Nurses	18,993	20,566	485,549	23.61	3
4	Licensed Practical Nurses	34,283	37,877	665,331	17.57	4
5	CNAs & Orderlies	134,928	149,239	1,747,897	11.71	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,252	4,708	48,221	10.24	8
9	Activity Director	1,837	2,181	20,211	9.27	9
10	Activity Assistants	6,694	7,568	63,108	8.34	10
11	Social Service Workers	7,730	8,975	115,746	12.90	11
12	Dietician					12
13	Food Service Supervisor	6,341	7,085	83,096	11.73	13
14	Head Cook	12,095	13,467	129,931	9.65	14
15	Cook Helpers/Assistants	32,517	35,339	263,697	7.46	15
16	Dishwashers					16
17	Maintenance Workers	6,052	7,022	140,102	19.95	17
18	Housekeepers	15,046	16,614	145,723	8.77	18
19	Laundry	11,067	12,153	99,725	8.21	19
20	Administrator	1,920	2,080	71,388	34.32	20
21	Assistant Administrator	1,860	2,203	58,405	26.51	21
22	Other Administrative					22
23	Office Manager	1,979	2,324	38,840	16.71	23
24	Clerical	10,204	11,842	124,140	10.48	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	1,753	2,095	27,975	13.35	31
32	Other Health Care(specify)	3,383	3,911	78,901	20.17	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	317,058	351,859	\$ 4,520,436 *	\$ 12.85	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	\$ 22,271		35
36	Medical Director	24,000		36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	2,600		39
40	Physical Therapy Consultant	90		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	3,720		46
47	COMPUTER SUPPORT	17,904		47
48				48
49	TOTAL (lines 35 - 48)	\$ 70,585		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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES, EXCEPT RN'S
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (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? NA
- (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? NA
- (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. \$ 60,281 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. NA
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 129,138
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? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 75%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ NA
- (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? NA
Attach invoices and a summary of services for all architect and appraisal fees.