

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786 Report Period Beginning: 12/1/08 Ending: 11/30/09

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other		Total
8	SNF	4,805	891	9,415	15,111	8
9	SNF/PED					9
10	ICF	34,645	7,315	356	42,316	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,450	8,206	9,771	57,427	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.24%

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 1/1/1974

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 7,148

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: 12/1/08-11/30/09

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/08 Ending: 11/30/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
A. General Services											
1	Dietary	511,553	61,180	31,331	604,064		604,064		604,064		1
2	Food Purchase		447,905		447,905		447,905		447,905		2
3	Housekeeping	165,660	33,029		198,689		198,689		198,689		3
4	Laundry	104,630	23,708		128,338		128,338		128,338		4
5	Heat and Other Utilities			207,023	207,023	(378)	206,645	(12,469)	194,176		5
6	Maintenance	142,150	29,464	84,587	256,201		256,201		256,201		6
7	Other (specify):* WASTE DISPOSAL			72,078	72,078		72,078		72,078		7
8	TOTAL General Services	923,993	595,286	395,019	1,914,298	(378)	1,913,920	(12,469)	1,901,451		8
B. Health Care and Programs											
9	Medical Director			24,000	24,000	(24,000)					9
10	Nursing and Medical Records	3,355,590	1,034,268	60,765	4,450,623		4,450,623		4,450,623		10
10a	Therapy			788,664	788,664		788,664		788,664		10a
11	Activities	82,931		1,283	84,214		84,214		84,214		11
12	Social Services	135,963		923	136,886		136,886		136,886		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* PLAN COORDINAT	98,383			98,383		98,383		98,383		15
16	TOTAL Health Care and Programs	3,672,867	1,034,268	875,635	5,582,770	(24,000)	5,558,770		5,558,770		16
C. General Administration											
17	Administrative	74,950			74,950		74,950		74,950		17
18	Directors Fees										18
19	Professional Services			3,100	3,100		3,100		3,100		19
20	Dues, Fees, Subscriptions & Promotions			17,019	17,019		17,019		17,019		20
21	Clerical & General Office Expenses	159,083	30,551	37,695	227,329		227,329		227,329		21
22	Employee Benefits & Payroll Taxes			1,106,575	1,106,575		1,106,575		1,106,575		22
23	Inservice Training & Education			2,089	2,089		2,089		2,089		23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			8,682	8,682		8,682		8,682		25
26	Insurance-Prop.Liab.Malpractice			62,221	62,221		62,221		62,221		26
27	Other (specify):*										27
28	TOTAL General Administration	234,033	30,551	1,237,381	1,501,965		1,501,965		1,501,965		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,830,893	1,660,105	2,508,035	8,999,033	(24,378)	8,974,655	(12,469)	8,962,186		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:

12/1/08

Ending:

11/30/09

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
30	D. Ownership											
	Depreciation			197,225	197,225		197,225		197,225			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,511	8,511		8,511		8,511			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			205,736	205,736		205,736		205,736			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Centers					24,000	24,000		24,000			39
40	Barber and Beauty Shops					378	378		378			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			129,758	129,758		129,758		129,758			42
43	Other (specify):* INTERNAL CO SERVICE			1,969,174	1,969,174		1,969,174	(1,969,174)				43
44	TOTAL Special Cost Centers			2,098,932	2,098,932	24,378	2,123,310	(1,969,174)	154,136			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,830,893	1,660,105	4,812,703	11,303,701		11,303,701	(1,981,643)	9,322,058			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: 12/1/08

Ending: 11/30/09

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	(12,469)	V5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule INTERNAL CO SERVICE	(1,969,174)	V43		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,981,643)		\$	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
	Amortization of Organization & Pre-Operating Expense			
33				33
	Adjustments for Related Organization Costs (Schedule VII)			
34				34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,981,643)		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			378	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)			\$ 378		47

VERMILION MANOR NURSING HOME

ID# 0000786

Report Period Beginning: 12/1/08

Ending: 11/30/09

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	Total		0	49

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.

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: 12/1/08 Ending: 11/30/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

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	Reporting Period Interest Expense										
											Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)
												YES	NO				Original	Balance		
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	77,732	2/15/2010	3.5000	8,511	3								
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related				\$26,038.00		\$ 888,593	\$ 77,732		\$ 8,511	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	\$ 77,732		\$ 8,511	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.)

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

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		\$ 2,051,544	4
5	95		1979	1979	1,961,500	49,038	40	49,038		1,490,951	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		69,086	10
11		FINAL CONSTRUCTION		1981	6,000	150	40	150		4,350	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		20			3,400	23
24		PVC RUB RAILS		1988	2,821		20			2,821	24
25		CANOPY REPAIRS		1988	12,075		20			12,075	25
26		REPLATE CERAMIC TILE		1988	2,485		20			2,485	26
27		TIME CLOCK/COMPUTER		1988	2,030		20			2,030	27
28		REPAIR CERAMIC TILE		1988	4,387		20			4,387	28
29		CONDITIONER		1988	17,116		15			17,116	29
30		WATER METER		1988	1,457		20			1,457	30
31		BUILDING IMPROVEMENTS		1989	334	2	20	2		334	31
32		DOOR O MATIC		1989	1,763	29	20	29		1,763	32
33		AIR CONDITIONERS		1990	146,034	7,302	20	7,302		142,110	33
34		FIRE RATED DOOR		1990	358	18	20	18		357	34
35		BUILDING IMPROVEMENTS		1990	163	8	20	8		162	35
36		WINDOW		1990	198	10	20	10		196	36

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

See Page 12A, Line 70 for total

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

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/08

Ending:

11/30/09

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	\$	\$ 13,913	37
38	CAPITAL IMPROVEMENTS	1990	18,139	907	20	907		17,912	38
39	HOT WATER STORAGE TANK	1990	4,589	229	20	229		4,513	39
40	AIR CONDITIONER UNITS	1990	6,602	330	20	330		6,409	40
41	ROOF REPAIR	1991	10,500	525	20	525		9,888	41
42	FIRE HYDRANT	1991	2,185	109	20	109		2,057	42
43	PUMPS	1991	1,700	85	20	85		1,594	43
44	AIR CONDITIONERS	1991	9,217	461	20	461		8,488	44
45	LOCK ON SERVICE DOORS	1991	55	3	20	3		50	45
46	CAPITAL IMPROVEMENTS	1991	1,370	68	20	68		1,244	46
47	FIRE DOOR AND SENSORS	1991	1,586	79	20	79		1,441	47
48	SHEETROCK AND BUILDING MATERIALS	1991	143	7	20	7		130	48
49	SIGNS	1991	122	6	20	6		110	49
50	LIGHT FIXTURES	1991	180	9	20	9		163	50
51	CAPITAL IMPROVEMENTS	1991	899	45	20	45		813	51
52	PLUMBING	1991	7,162	358	20	358		6,475	52
53	CORNER GUARDS	1991	367	18	20	18		331	53
54	AIR HANDLER	1991	3,661	183	20	183		3,295	54
55	CAPITAL IMPROVEMENTS	1992	4,880	244	20	244		4,351	55
56	GENERATOR	1992	19,380	969	20	969		17,200	56
57	PLUMBING	1992	11,543	577	20	577		10,244	57
58	PLUMBING	1992	21,222	1,061	20	1,061		18,746	58
59	GENERATOR	1992	46,548	2,327	20	2,327		40,923	59
60	PLUMBING	1992	21,293	1,065	20	1,065		18,720	60
61	CAPITAL IMPROVEMENTS	1992	11,616	581	20	581		10,213	61
62	LIGHT FIXTURES	1992	1,395	70	20	70		1,220	62
63	PLUMBING	1992	8,826	441	20	441		7,723	63
64	AIR CONDITIONER	1992	2,765	138	20	138		2,385	64
65	AIR CONDITIONER	1992	5,368	268	20	268		4,630	65
66	CAPITAL IMPROVEMENTS	1992	4,452	223	20	223		3,803	66
67	REROOFING	1993	4,000	200	20	200		3,350	67
68	WALK IN FREEZER	1993	11,400	570	20	570		9,500	68
69	CALL MASTER STATION	1993	3,215		15			3,215	69
70	TOTAL (lines 4 thru 69)		\$ 5,039,341	\$ 128,976		\$ 128,976	\$	\$ 4,276,145	70

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

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/08

Ending:

11/30/09

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	\$ 128,976		\$ 128,976	\$	\$ 4,276,145	1
2	CAPITAL IMPROVEMENTS	1993	4,968	248	20	248		4,099	2
3	ROOFING	1993	32,207	1,610	20	1,610		26,437	3
4	ROOFING	1993	2,775	139	20	139		2,278	4
5	SMOKING ROOM	1993	6,511	326	20	326		5,344	5
6	A LOUNGE WALL	1993	1,004	50	20	50		816	6
7	KITCHEN	1993	4,984	249	20	249		4,008	7
8	HOT WATER HEATER	1993	5,987	299	20	299		4,690	8
9	ACTIVATOR	1994	1,190	60	20	60		932	9
10	LABOT DAMPERS	1994	3,082	154	20	154		2,376	10
11	CALL SYSTEM	1994	3,427	171	20	171		2,570	11
12	GARAGE	1994	4,050	203	20	203		3,037	12
13	ROOFING	1994	38,981	1,949	20	1,949		29,236	13
14	DOOR OPENER	1994	2,849	142	20	142		2,137	14
15	CAPITAL IMPROVEMENTS	1994	4,952	247	20	247		3,714	15
16	GARAGE	1994	1,403	70	10	70		1,052	16
17	BOOSTER HEATER	1994	4,320		10			4,320	17
18	CALL LIGHT SYSTEM	1995	3,577		10			3,577	18
19	FOLDING PARTITION	1995	4,880		20			4,880	19
20	REWIRE GARAGE	1995	650	33	10	33		455	20
21	EXHAUST SYSTEM	1995	5,346		15			5,346	21
22	FRONT ENTRANCE	1996	1,050	70	15	70		939	22
23	DRIVEWAY	1996	10,170	678	15	678		9,040	23
24	CANOPY	1996	19,619	1,308	15	1,308		17,221	24
25	TILE REPLACEMENT	1996	1,129		10			1,129	25
26	ROOF REPAIR	1996	30,645	1,532	20	1,532		19,025	26
27	REPAIR DRIVE	1997	2,900		10			2,900	27
28	AIR CONDITIONER UNITS	1997	15,322	766	20	766		9,385	28
29	WATER HEATER	1998	6,200		10			6,200	29
30	ROOF	1998	21,809		10			21,809	30
31	AIR CONDITIONER UNITS	1998	9,160	458	20	458		5,076	31
32	CAPITAL IMPROVEMENTS	1998	1,012		10			1,013	32
33	AIR CONDITIONER UNITS	1998	8,580	430	20	430		4,719	33
34	TOTAL (lines 1 thru 33)		\$ 5,304,080	\$ 140,168		\$ 140,168	\$	\$ 4,485,905	34

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

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	10
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	\$ 140,168		\$ 140,168		\$ 4,485,905		1
2	AIR CONDITIONERS UNITS	1999 49,921	2,496	20	2,496		25,792		2
3	ROOF	1999 22,973	1,149	20	1,149		11,870		3
4	CANOPY REPAIR	1999 7,630	382	20	382		3,910		4
5	GENERATOR	1999 7,951	398	20	398		3,810		5
6	WATER HEATER	2000 8,368	418	20	418		3,905		6
7	CONDENSER	2000 2,350	118	20	118		1,087		7
8	CANOPY REPAIR	2001 7,700	513	15	513		4,534		8
9	HOT WATER HEATER	2001 1,634	163	10	163		1,403		9
10	ELECTRIC BOOSTER HEATER	2001 1,639	164	10	164		1,379		10
11	BOILER REPAIR	2001 23,800	1,587	15	1,587		12,958		11
12	AIR CONDITIONER UNITS	2001 8,367	418	20	418		2,928		12
13	LIGHTING RENOVATIONS	2002 8,402	420	20	420		2,941		13
14	PARKING LOT IMPROVEMENTS	2003 4,800	320	15	320		2,000		14
15	BOILERS	2004 2,529	169	15	169		997		15
16	CARPETING	2004 1,564	156	10	156		782		16
17	WATER HEATER	2004 4,807	481	10	481		2,404		17
18	SPRINKLER SYSTEM	2004 103,956	10,396	10	10,396		51,978		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	\$ 159,916		\$ 159,916		\$ 4,620,583		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	\$ 782,323	\$ 28,129	\$ 28,129	\$ (0)	VARIOUS	\$ 744,367	71
72	Current Year Purchases	45,810	5,458	5,458		5	5,458	72
73	Fully Depreciated Assets	355,817					355,817	73
74								74
75	TOTALS	\$ 1,183,950	\$ 33,587	\$ 33,587	\$ (0)		\$ 1,105,642	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	RESIDENT TRANSPORT	CHEVY VAN W/ LIFTS 2002	2002	24,602					24,602	77
78	MAINTENANCE	FORD TRUCK 2009	2009	24,814	3,722	3,722		5	3,722	78
79										79
80	TOTALS			\$ 71,712	\$ 3,722	\$ 3,722	\$		\$ 50,620	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)	\$ 6,828,133	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 197,225	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 197,225	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (0)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,776,845	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

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

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

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

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

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

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,978,189	\$ 1
2	Cash-Patient Deposits	40,456	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 115,000)	1,120,532	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)	\$ 4,831,955	\$ 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 Cos		15
16	Equipment, at Historical Cost	1,274,831	16
17	Accumulated Depreciation (book methods)	(5,796,014)	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)	\$ 1,051,288	\$ 24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,883,243	\$ 25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26	Accounts Payable	\$ 807,327	\$ 26
27	Officer's Accounts Payable		27
28	Accounts Payable-Patient Deposits	40,456	28
29	Short-Term Notes Payable		29
30	Accrued Salaries Payable	192,458	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	983,696	36
37	DEFERRED REVENUE	692,778	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,716,715	\$ 38
D. Long-Term Liabilities			
39	Long-Term Notes Payable		39
40	Mortgage Payable		40
41	Bonds Payable		41
42	Deferred Compensation		42
Other Long-Term Liabilities(specify):			
43			43
44			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,716,715	\$ 46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,166,528	\$ 47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,883,243	\$ 48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,959,019	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,959,019	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,207,509	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)	\$ 1,207,509	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 3,166,528	24 *

* This must agree with page 17, line 47.

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

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

1

Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,727,477	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,727,477	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***	42,454	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 42,454	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	MISCELLANEOUS - SEE ATTACHED	48,576	28
28a	PROPERTY TAX REVENUE	692,703	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 741,279	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,511,210	30

2

Expenses		Amount	
A. Operating Expenses			
31	General Services	1,914,298	31
32	Health Care	5,582,770	32
33	General Administration	1,501,965	33
B. Capital Expense			
34	Ownership	205,736	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	129,758	36
D. Other Expenses (specify):			
37	INTERNAL CO SERVICE	1,969,174	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,303,701	40
41	Income before Income Taxes (line 30 minus line 40)**	1,207,509	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,207,509	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

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	3,968	4,332	\$ 67,436	\$ 15.57	1
2	Assistant Director of Nursing	1,955	2,171	58,742	27.06	2
3	Registered Nurses	29,008	30,888	824,265	26.69	3
4	Licensed Practical Nurses	23,791	25,816	517,581	20.05	4
5	CNAs & Orderlies	129,836	142,139	1,810,243	12.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,506	3,866	44,205	11.43	8
9	Activity Director	1,650	1,982	20,298	10.24	9
10	Activity Assistants	5,495	6,163	62,633	10.16	10
11	Social Service Workers	9,050	10,120	135,963	13.44	11
12	Dietician					12
13	Food Service Supervisor	5,287	5,832	78,017	13.38	13
14	Head Cook	9,262	10,102	110,820	10.97	14
15	Cook Helpers/Assistants	30,005	32,678	322,716	9.88	15
16	Dishwashers					16
17	Maintenance Workers	9,525	10,076	142,150	14.11	17
18	Housekeepers	15,306	16,614	165,660	9.97	18
19	Laundry	10,144	11,077	104,630	9.45	19
20	Administrator	1,920	2,080	74,950	36.03	20
21	Assistant Administrator	1,732	1,969	61,113	31.04	21
22	Other Administrative					22
23	Office Manager	1,858	2,028	39,777	19.61	23
24	Clerical	3,434	3,890	58,193	14.96	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	1,927	2,278	33,118	14.54	31
32	Other Health Care(specify)	3,598	3,891	98,383	25.28	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	302,257	329,992	\$ 4,830,893 *	\$ 14.64	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	\$ 31,331		35
36	Medical Director	24,000		36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	14,462		39
40	Physical Therapy Consultant	288		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	3,100		46
47	COMPUTER SUPPORT	14,766		47
48				48
49	TOTAL (lines 35 - 48)	\$ 87,947		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

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
JOAN DARR	ADMINISTRATOR		\$ 74,950	Workers' Compensation Insurance	\$ 94,120	IDPH License Fee	\$		
				Unemployment Compensation Insurance	24,413	Advertising: Employee Recruitment	4,819		
				FICA Taxes	347,058	Health Care Worker Background Check			
				Employee Health Insurance	276,362	(Indicate # of checks performed 150)	3,000		
				Employee Meals	0	DUES AND FEES	8,710		
				Illinois Municipal Retirement Fund (IMRF)*	358,494	STATE MARSHALL	490		
				EMPLOYEE FRINGE BENEFITS	5,828				
				EMPLOYEE PHYSICALS	300				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 74,950	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,106,575			
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$				Seminar Expense		
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,100	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning: 12/1/08

Ending: 11/30/09

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES, EXCEPT RN'S
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 60,541 Line 10/2
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 129,758
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? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: CLIFTON GUNDERSON
- (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 service performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees