

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786 Report Period Beginning: 12/1/12 Ending: 7/31/13

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	34,506	1
2		Skilled Pediatric (SNF/PED)			2
3	95	Intermediate (ICF)	95	23,085	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	237	TOTALS	237	57,591	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	2,601		3,372	5,973	8
9	SNF/PED					9
10	ICF	23,849	3,795	552	28,196	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,450	3,795	3,924	34,169	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.33%

D. How many bed-hold days during this year were paid by the Department? _____

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 01/01/1974

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 142 and days of care provided 3,218

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: N/A Fiscal Year: 12/1/12-7/31/13

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

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	309,551	30,977	22,641	363,169		363,169	363,169			1
2	Food Purchase		300,965		300,965		300,965	300,965			2
3	Housekeeping	120,569	27,184		147,753		147,753	147,753			3
4	Laundry	62,017	19,678		81,695		81,695	81,695			4
5	Heat and Other Utilities			117,221	117,221	(192)	117,029	(12,182)	104,847		5
6	Maintenance	44,405	64,014	213,564	321,983		321,983	321,983			6
7	Other (specify):*			29,022	29,022		29,022	29,022			7
8	TOTAL General Services	536,542	442,818	382,448	1,361,808	(192)	1,361,616	(12,182)	1,349,434		8
	B. Health Care and Programs										
9	Medical Director			14,000	14,000	(14,000)					9
10	Nursing and Medical Records	2,525,898	464,465	42,705	3,033,068		3,033,068	3,033,068			10
10a	Therapy	34,875		805,437	840,312		840,312	840,312			10a
11	Activities	63,405		1,155	64,560		64,560	64,560			11
12	Social Services	88,035		532	88,567		88,567	88,567			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* Plan Coordinator	39,781			39,781		39,781	39,781			15
16	TOTAL Health Care and Programs	2,751,994	464,465	863,829	4,080,288	(14,000)	4,066,288	4,066,288			16
	C. General Administration										
17	Administrative	56,981			56,981		56,981	56,981			17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			3,906	3,906		3,906	3,906			20
21	Clerical & General Office Expenses	83,077	60,206	33,838	177,121		177,121	177,121			21
22	Employee Benefits & Payroll Taxes			1,037,538	1,037,538		1,037,538	1,037,538			22
23	Inservice Training & Education			2,399	2,399		2,399	2,399			23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation			7,186	7,186		7,186	7,186			25
26	Insurance-Prop.Liab.Malpractice			68,063	68,063		68,063	68,063			26
27	Other (specify):*			654,216	654,216		654,216	(654,216)			27
28	TOTAL General Administration	140,058	60,206	1,807,146	2,007,410		2,007,410	(654,216)	1,353,194		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,428,594	967,489	3,053,423	7,449,506	(14,192)	7,435,314	(666,398)	6,768,916		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:

12/1/12

Ending:

7/31/13

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			133,671	133,671		133,671		133,671			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			133,671	133,671		133,671		133,671			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					14,000	14,000		14,000			39
40	Barber and Beauty Shops					192	192		192			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers					14,192	14,192		14,192			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,428,594	967,489	3,187,094	7,583,177		7,583,177	(666,398)	6,916,779			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: 12/1/12

Ending: 7/31/13

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	(12,182)	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	(654,216)	V27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (666,398)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (666,398)		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			192	V5	41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 192		47

BHF USE ONLY						
48		49		50		51
						52

VERMILION MANOR NURSING HOME

ID# 0000786

Report Period Beginning: 12/1/12

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Sch. V Line

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
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/12

Ending:

7/31/13

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number VERMILION MANOR NURSING HOME# 0000786

Report Period Beginning:

12/1/12

Ending:

7/31/13

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

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

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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

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

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

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

Facility Name & ID Number

VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/12

Ending:

7/31/13

VII. RELATED PARTIES

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

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

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/12 Ending: 7/31/13

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

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12/1/12

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

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.)

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 2012 report.		\$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		\$ N/A	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$ N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$ N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ N/A	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2008	<u>N/A</u>	8
	2009	<u>N/A</u>	9
	2010	<u>N/A</u>	10
	2011	<u>N/A</u>	11
	2012	<u>N/A</u>	12
	FOR BHF USE ONLY		
	13	FROM R. E. TAX STATEMENT FOR 2012 \$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME VERMILION MANOR NURSING HOME COUNTY VERMILION

FACILITY IDPH LICENSE NUMBER 0000786

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2012 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 2012.

	(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	\$ <u>_____</u>	\$ <u>_____</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786 Report Period Beginning:

12/1/12 Ending:

7/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 74,000 B. General Construction Type: Exterior BRICK Frame SINGLE STORY Number of Stories ONE

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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	\$ 38,168	40	\$ 38,168	\$ (0)	\$ 2,261,471	4
5	95	1979	1979	1,961,500	32,692	40	32,692	0	1,670,755	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	1,535	40	1,535		77,529	10
11	FINAL CONSTRUCTION BILLS		1981	6,000	100	40	100		4,900	11
12	ROOF		1982	40,042		10			40,042	12
13	PUMP		1982	9,414		10			9,414	13
14	ROOF		1983	39,569		10			39,569	14
15	ROOF		1984	52,663		10			52,663	15
16	WATER HEATER		1985	26,025		10			26,025	16
17	DRIVEWAY		1985	4,200		10			4,200	17
18	FASTEN EATIA SYSTEM		1986	1,438		10			1,438	18
19	WATER LINE		1986	2,904		10			2,904	19
20	ACQUAMATIC		1986	2,386		10			2,386	20
21	FENCE		1986	609		10			609	21
22	LINT CATCHER		1986	5,981		10			5,981	22
23	PARKING LOT/GARAGE		1986	26,927		10			26,927	23
24	ROOF		1986	3,470		10			3,470	24
25	KITCHEN DUCT WORK		1988	2,644		10			2,643	25
26	400 AMP LINE		1988	3,400		20			3,400	26
27	PVC RUB RAILS		1988	2,821		20			2,821	27
28	CANOPY REPAIR		1988	12,075		20			12,075	28
29	REPLATE CERAMIC TILES		1988	2,485		20			2,485	29
30	ELECTRIC		1988	2,030		20			2,030	30
31	REPAIR CERAMIC TILES		1988	4,387		20			4,387	31
32	CONDITIONER		1988	17,116		20			17,115	32
33	WATER METER		1988	1,457		15			1,457	33
34	BUILDING IMPROVEMENTS		1989	334		20			334	34
35	DOOR O'MATIC		1989	1,763		20			1,763	35
36	AIR CONDITIONER		1989	146,034		20			146,033	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/12

Ending:

7/31/13

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	FIRE RATED DOOR	1990	\$ 358	\$	20	\$	\$	\$ 358	37
38	BUILDING IMPROVEMENTS	1990	163		20			163	38
39	WINDOW	1990	198		20			198	39
40	AIR CONDITIONERS	1990	14,149		20			14,149	40
41	CAPITAL IMPROVEMENTS	1990	18,139		20			18,139	41
42	HOT WATER STORAGE TANK	1990	4,589		20			4,589	42
43	NEW AIR CONDITIONER	1990	6,602		20			6,602	43
44	ROOF REPAIR	1991	10,500		20			10,500	44
45	FIRE HYDRANT	1991	2,185		20			2,185	45
46	PUMPS	1991	1,700		20			1,700	46
47	AIR CONDITIONERS	1991	9,217		20			9,217	47
48	LOCK ON SERVICE DOOR	1991	55		20			55	48
49	CAPITAL IMPROVEMENTS	1991	1,370		20			1,370	49
50	FIRE DOOR AND SENSORS	1991	1,586		20			1,586	50
51	SHEETROCK AND BUILDING MATERIALS	1991	143		20			143	51
52	SIGNS	1991	122		20			122	52
53	LIGHT FIXTURES	1991	180		20			180	53
54	CAPITAL IMPROVEMENTS	1991	899		20			899	54
55	PLUMBING	1991	7,162		20			7,162	55
56	CORNER GUARDS	1991	367		20			367	56
57	AIR HANDLER	1991	3,661		20			3,661	57
58	CAPITAL IMPROVEMENTS	1992	4,880		20			4,880	58
59	GENERATOR	1992	19,380		20			19,380	59
60	PLUMBING	1992	11,543		20			11,543	60
61	PLUMBING	1992	21,222		20			21,222	61
62	GENERATOR	1992	46,548		20			46,548	62
63	PLUMBING	1992	21,293		20			21,293	63
64	IMPROVEMENTS	1992	11,616		20			11,616	64
65	LIGHT FIXTURES	1992	1,395		20			1,395	65
66	PLUMBING	1992	8,826		20			8,826	66
67	AIR CONDITIONERS	1992	2,765		20			2,765	67
68	AIR CONDITIONERS	1992	5,368		20			5,368	68
69	IMPROVEMENTS	1992	4,452		20			4,452	69
70	TOTAL (lines 4 thru 69)		\$ 5,020,726	\$ 72,495		\$ 72,495	\$ (0)	\$ 4,685,659	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:

12/1/12

Ending:

7/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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		\$ 5,020,726	\$ 72,495		\$ 72,495	\$ (0)	\$ 4,685,659	1
2	REROOFING PLANS	1993	4,000	50		50		4,000	2
3	WALK IN FREEZER	1993	11,400	190		190		11,400	3
4	CALL MASTER	1993	3,215					3,215	4
5	MISC CAPITAL IMPROVEMENTS	1993	4,968	124		124		4,968	5
6	ROOFING	1993	32,207	939		939		32,207	6
7	ROOFING SUPERVISION	1993	2,775	81		81		2,775	7
8	SMOKING ROOM PARTS & LAB	1993	6,511	190		190		6,511	8
9	LOUNGE WALL/SUPPLIES	1993	1,004	33		33		1,000	9
10	PTS/LABOR KITCHEN	1993	4,984	166		166		4,922	10
11	80 GAL HOT WATER HEATER	1994	5,987	200		200		5,787	11
12	REG ACTIVATOR	1994	1,190	40		40		1,150	12
13	LABOT DAMPER	1994	3,082	103		103		2,941	13
14	CALL SYSTEM	1994	3,427	114		114		3,199	14
15	GARAGE	1994	4,050	135		135		3,780	15
16	ROOFING WORK	1994	38,981	1,299		1,299		36,382	16
17	DOOR OPENER	1994	2,849	95		95		2,659	17
18	MISC CAPITAL IMPROVEMENTS	1994	4,952	165		165		4,622	18
19	GARAGE	1994	1,403	47		47		1,309	19
20	BOOSTER HEATER	1995	4,320					4,320	20
21	CALL LIGHT SYSTEM	1995	3,577					3,577	21
22	FOLDING PARTITION	1995	4,880					4,880	22
23	REWIRE GARAGE	1995	650	22		22		574	23
24	EXHAUST SYSTEM	1996	5,346					5,346	24
25	CONCRETE WORK	1996	1,050					1,050	25
26	CONCRETE WORK - DRIVEWAY	1996	10,170					10,170	26
27	CANOPY	1996	19,619					19,619	27
28	TILE REPLACEMENT	1996	1,129					1,129	28
29	ROOF REPAIR	1997	30,645	1,022		1,022		24,644	29
30	REPAIR DRIVE	1997	2,900					2,900	30
31	AIR CONDITIONER	1997	15,322	511		511		12,194	31
32	WATER HEATER	1998	6,200					6,200	32
33	ROOF	1998	21,809					21,809	33
34	TOTAL (lines 1 thru 33)		\$ 5,285,328	\$ 78,021		\$ 78,021	\$ (0)	\$ 4,936,898	34

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

Facility Name & ID Number VERMILION MANOR NURSING HOME

0000786

Report Period Beginning:

12/1/12

Ending:

7/31/13

XI. OWNERSHIP COSTS (continued)**B. Building and Improvement Costs-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		\$ 5,285,328	\$ 78,021		\$ 78,021	\$ (0)	\$ 4,936,898	1
2	AIR CONDITIONER	1998	9,160	305	20	305		6,754	2
3	AIR CONDITIONER	1998	8,580	286	20	286		6,292	3
4	CAPITAL IMPROVEMENTS	1998	1,012		10			1,012	4
5	AIR CONDITIONER	1999	49,921	1,664	20	1,664		34,945	5
6	NEW ROOF	1999	22,973	766	20	766		16,081	6
7	CANOPY REPAIR	1999	7,630	254	20	254		5,309	7
8	GENERATOR	2000	7,951	265	20	265		5,268	8
9	WATER HEATER	2000	8,368	279	20	279		5,439	9
10	CONDENSER	2000	2,350	78	20	78		1,518	10
11	CANOPY REPAIR	2001	7,700	342	15	342		6,417	11
12	WATER HEATER	2001	1,634		10			1,634	12
13	ELECTRIC BOOSTER HEATER	2001	1,639		10			1,639	13
14	BOILER REPAIR	2001	23,800	1,058	15	1,058		18,776	14
15	AIR CONDITIONER	2002	8,367	279	20	279		4,462	15
16	LIGHTING	2002	8,402	280	20	280		4,481	16
17	PARKING LOT IMPROVEMENT	2003	4,800	213	15	213		3,173	17
18	BOILERS	2004	2,529	112	15	112		1,616	18
19	CARPETING	2004	1,564	104	10	104		1,356	19
20	WATER HEATER	2004	4,807	321	10	321		4,167	20
21	SPRINKLER SYSTEM	2004	103,956	6,930	10	6,930		90,096	21
22	COMMUNOTOR FOR WASTE TREATMENT SYSTEM	2010	11,338	756	10	756		3,874	22
23	KITCHEN EXHAUST FAN	2010	5,350	357	10	357		1,516	23
24	FIRE ALARM UPGRADE	2010	25,800	1,720	10	1,720		7,310	24
25	STEEL DOOR, SCREWS, NAILS, PLYWOOD	2011	2,642	176	10	176		617	25
26	ELECTRICAL OUTLETS	2011	5,799	387	10	387		1,257	26
27	SEWER ROUTER	2011	534	36	10	36		111	27
28	ELECTRICAL EQUIPMENT	2011	5,628	375	10	375		1,219	28
29	WINDOW A/C	2011	826	110	5	110		330	29
30	LABOR AND MATERIAL FOR DRAIN LINE REPAIR	2011	21,514	1,434	10	1,434		4,482	30
31	REPAIRS	2011	1,023	68	10	68		222	31
32	ROOF	2012	175,790	5,860	20	5,860		5,860	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,828,715	\$ 102,836		\$ 102,836	\$ (0)	\$ 5,184,131	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 758,201	\$ 22,910	\$ 22,910	\$		\$ 683,001	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	550,609					550,609	73
74								74
75	TOTALS	\$ 1,308,810	\$ 22,910	\$ 22,910	\$		\$ 1,233,610	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	RESIDENTIAL TRANSPORTATION	FORD VAN	1996	\$ 22,296	\$	\$	\$		\$ 22,296	76
77	RESIDENTIAL TRANSPORTATION	FORD VAN W/LIFTS	2002	24,602					24,602	77
78	MAINTENANCE		2009	24,814	3,308	3,308			21,918	78
79	RESIDENTIAL TRANSPORTATION	VAN W/LIFTS	2010	34,631	4,617	4,617			24,314	79
80	TOTALS			\$ 106,343	\$ 7,925	\$ 7,925	\$		\$ 93,130	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 7,243,868	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 133,671	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 133,671	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)	\$ 6,510,871	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

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. _____ /2014 \$ _____

13. _____ /2015 \$ _____

14. _____ /2016 \$ _____

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.

Facility Name & ID Number VERMILION MANOR NURSING HOME # 0000786 Report Period Beginning: 12/1/12 Ending: 7/31/13
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <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. <u>CLASSROOM PORTION:</u></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. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							4	
5	Physician Care	line 39(8)	17 visits			14,000		17	14,000	5	
6	Dental Care		visits							6	
7	Work Related Program		hrs							7	
8	Habilitation		hrs							8	
9	Pharmacy		# of prescrpts							9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify):									12	
13	Other (specify):									13	
14	TOTAL			\$		\$ 14,000	\$	17	\$ 14,000	14	

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

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

0000786

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

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **7/31/13** (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	\$ 1,617,016	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>175,000</u>)	1,374,181		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):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,991,197	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	5,828,715		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,415,153		16
17	Accumulated Depreciation (book methods)	(6,510,871)		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)	\$ 732,997	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,724,194	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			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				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	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)	\$	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,724,194	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,724,194	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,328,640	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,328,640	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(604,446)	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)	\$ (604,446)	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)	\$ 3,724,194	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		
I. Revenue		Amount		
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$ 6,226,340		1
2	Discounts and Allowances for all Levels	()		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,226,340		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***	378		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 378		26
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)			27
28	MISCELLANEOUS - SEE ATTACHED	55,054		28
28a	PROPERTY TAX REVENUE	696,959		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 752,013		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,978,731		30

		2		
II. Expenses		Amount		
A. Operating Expenses				
31	General Services	1,361,808		31
32	Health Care	4,080,288		32
33	General Administration	2,007,410		33
B. Capital Expense				
34	Ownership	133,671		34
C. Ancillary Expense				
35	Special Cost Centers			35
36	Provider Participation Fee			36
D. Other Expenses (specify):				
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,583,177		40
41	Income before Income Taxes (line 30 minus line 40)**	(604,446)		41
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (604,446)		43

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

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

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

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

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

Facility Name & ID Number VERMILION MANOR NURSING HOME

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Report Period Beginning:

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,127	1,368	\$ 54,313	\$ 39.70	1
2	Assistant Director of Nursing	1,137	1,194	43,237	36.21	2
3	Registered Nurses	24,087	26,679	685,563	25.70	3
4	Licensed Practical Nurses	17,097	18,470	359,908	19.49	4
5	CNAs & Orderlies	84,149	94,242	1,328,575	14.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,036	3,152	34,875	11.06	8
9	Activity Director	1,230	1,653	17,885	10.82	9
10	Activity Assistants	4,421	5,009	45,520	9.09	10
11	Social Service Workers	5,319	6,092	88,035	14.45	11
12	Dietician					12
13	Food Service Supervisor	2,359	2,609	52,227	20.02	13
14	Head Cook	11,108	12,105	117,529	9.71	14
15	Cook Helpers/Assistants	14,732	16,301	139,795	8.58	15
16	Dishwashers					16
17	Maintenance Workers	3,878	4,236	44,405	10.48	17
18	Housekeepers	11,103	12,300	120,569	9.80	18
19	Laundry	6,287	7,102	62,017	8.73	19
20	Administrator	1,320	1,360	56,981	41.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,530	1,754	41,629	23.73	23
24	Clerical	2,213	2,506	41,448	16.54	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	1,199	1,503	24,302	16.17	31
32	Other Health Care(specify)	2,456	2,832	69,781	24.64	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	199,788	222,467	\$ 3,428,594 *	\$ 15.41	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	\$ 22,641		35
36	Medical Director	14,000		36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant			39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant			44
45	Social Service Consultant			45
46	Other(specify) <u>FR&R</u>	3,800		46
47	<u>COMPUTER SUPPORT</u>	19,202		47
48				48
49	TOTAL (lines 35 - 48)	\$ 59,643		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
TRACY MCCRAE	ADMINISTRATOR		\$ 56,981	Workers' Compensation Insurance	\$ 61,794	IDPH License Fee	\$	
				Unemployment Compensation Insurance	26,069	Advertising: Employee Recruitment		
				FICA Taxes	303,966	Health Care Worker Background Check		
				Employee Health Insurance	264,939	(Indicate # of checks performed <u>120</u>)	1,200	
				Employee Meals	0	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*	377,488	DUES AND FEES	2,706	
				EMPLOYEE BENEFITS	2,790			
				EMPLOYEE PHYSICALS	492			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 56,981	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,037,538		
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)			\$	TOTAL		\$	Seminar Expense	
C. Professional Services							Entertainment Expense (agree to Sch. V, line 24, col. 8)	
Vendor/Payee	Type		Amount				TOTAL	\$
FR&R	MEDICAL CONSULTANT		\$ 3,800					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 3,800					

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20	TOTALS	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility Name & ID Number VERMILION MANOR NURSING HOME

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES, EXCEPT RN
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,866 Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 0
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 75%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: CliftonLarsonAllen LLP
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.