

		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

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

I. IDPH Facility ID Number: 0038661

Facility Name: VIP Manor

Address: 393 Edwardsville Road Wood River 62095
 Number City Zip Code

County: Madison

Telephone Number: (618) 259-4111 **Fax #** (618) 259-5791

HFS ID Number: 95-3750883014

Date of Initial License for Current Owners: 12/31/1985

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Greg LeRoy **Telephone Number:** (479) 201-4371

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____ <u>03/28/2006</u> (Date)
	(Type or Print Name) <u>Greg Swartz</u>
Paid Preparer	(Title) <u>Assistant Secretary</u>
	(Signed) _____ (Date)
Paid Preparer	(Print Name and Title) _____
	(Firm Name & Address) _____
	(Telephone) () _____ Fax # () _____
	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number VIP Manor

0038661 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	106	Skilled (SNF)	106	38,690	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	2,111	5,879	4,737	12,727	8
9	SNF/PED					9
10	ICF	22,179			22,179	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,290	5,879	4,737	34,906	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.22%

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

121 (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)

None

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 12/31/1985

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

YES Date 12/31/1985 NO

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

YES NO If YES, enter number of beds certified 52 and days of care provided 4,501

Medicare Intermediary United Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

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

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	177,403	14,068	236	191,707		191,707	1,695	193,402			1
2	Food Purchase		166,296		166,296		166,296	(9,527)	156,769			2
3	Housekeeping		433	90,961	91,394		91,394	14	91,408			3
4	Laundry		11,812	60,271	72,083		72,083		72,083			4
5	Heat and Other Utilities			117,818	117,818		117,818	(813)	117,005			5
6	Maintenance	36,414	8,620	36,268	81,302		81,302	(918)	80,384			6
7	Other (specify):*			3,050	3,050		3,050		3,050			7
8	TOTAL General Services	213,817	201,229	308,604	723,650		723,650	(9,549)	714,101			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,816,895	99,183	49,710	1,965,788	(13,161)	1,952,627	4,341	1,956,968			10
10a	Therapy		1,366	393,893	395,259	(1,366)	393,893	(127,726)	266,167			10a
11	Activities	42,091	1,662	1,346	45,099		45,099	55	45,154			11
12	Social Services	50,180	375	3,230	53,785		53,785		53,785			12
13	CNA Training											13
14	Program Transportation			4,957	4,957		4,957	(90)	4,867			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,909,166	102,586	471,136	2,482,888	(14,527)	2,468,361	(123,420)	2,344,941			16
	C. General Administration											
17	Administrative			313,513	313,513	92,041	405,554	45,246	450,800			17
18	Directors Fees											18
19	Professional Services			5,604	5,604		5,604		5,604			19
20	Dues, Fees, Subscriptions & Promotions			48,600	48,600		48,600	(16,947)	31,653			20
21	Clerical & General Office Expenses	182,939	21,069	80,453	284,461	(92,041)	192,420	(78,670)	113,750			21
22	Employee Benefits & Payroll Taxes			450,364	450,364		450,364	(37,518)	412,846			22
23	Inservice Training & Education			5,227	5,227		5,227	(541)	4,686			23
24	Travel and Seminar			9,026	9,026		9,026	(983)	8,043			24
25	Other Admin. Staff Transportation			911	911		911		911			25
26	Insurance-Prop.Liab.Malpractice			150,879	150,879		150,879	97,456	248,335			26
27	Other (specify):*											27
28	TOTAL General Administration	182,939	21,069	1,064,577	1,268,585		1,268,585	8,043	1,276,628			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,305,922	324,884	1,844,317	4,475,123	(14,527)	4,460,596	(124,926)	4,335,670			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 VIP Manor #0038661 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			177,028	177,028		177,028	(106,016)	71,012			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(2)	(2)		(2)	2				32
33	Real Estate Taxes			126,878	126,878		126,878	2,309	129,187			33
34	Rent-Facility & Grounds			575,334	575,334		575,334		575,334			34
35	Rent-Equipment & Vehicles			34,519	34,519		34,519	(234)	34,285			35
36	Other (specify):*											36
37	TOTAL Ownership			913,757	913,757		913,757	(103,939)	809,818			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		137,137		137,137	2,106	139,243	(139,243)				39
40	Barber and Beauty Shops			537	537		537	(537)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							58,035	58,035			42
43	Other (specify):*		9,905	20,107	30,012	12,421	42,433	(42,433)				43
44	TOTAL Special Cost Centers		147,042	20,644	167,686	14,527	182,213	(124,178)	58,035			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,305,922	471,926	2,778,718	5,556,566		5,556,566	(353,043)	5,203,523			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 VIP Manor

0038661

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,833)	2		4
5	Telephone, TV & Radio in Resident Rooms				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	(139)	2		13
14	Non-Care Related Interest	2	32		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	5,395	27		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	(56,010)	21		24
25	Fund Raising, Advertising and Promotional	(20,423)	20		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	(314,905)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (392,913)		\$	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)	(69,242)	17	34
35	Other- Attach Schedule	109,112		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 39,870		36
37	TOTAL ADJUSTMENTS (A) and (B)	\$ (353,043)		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY						
48		49		50		51
						52

VIP Manor

ID# 0038661

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line 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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number VIP Manor# 0038661

Report Period Beginning:

01/01/2005

Ending:

12/31/2005**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	(634)	2,329	0	0	0	0	0	0	0	0	0	1,695	1
2	Food Purchase	(9,865)	338	0	0	0	0	0	0	0	0	0	(9,527)	2
3	Housekeeping	14	0	0	0	0	0	0	0	0	0	0	14	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(813)	0	0	0	0	0	0	0	0	0	0	(813)	5
6	Maintenance	(918)	0	0	0	0	0	0	0	0	0	0	(918)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(12,216)	2,667	0	(9,549)	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	(6,225)	10,566	0	0	0	0	0	0	0	0	0	4,341	10
10a	Therapy	0	(127,726)	0	0	0	0	0	0	0	0	0	(127,726)	10a
11	Activities	55	0	0	0	0	0	0	0	0	0	0	55	11
12	Social Services	(14)	14	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	(90)	0	0	0	0	0	0	0	0	0	0	(90)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(6,274)	(117,146)	0	(123,420)	16								
	C. General Administration													
17	Administrative	3,203	42,043	0	0	0	0	0	0	0	0	0	45,246	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	(16,947)	0	0	0	0	0	0	0	0	0	0	(16,947)	20
21	Clerical & General Office Expenses	(78,670)	0	0	0	0	0	0	0	0	0	0	(78,670)	21
22	Employee Benefits & Payroll Taxes	(37,518)	0	0	0	0	0	0	0	0	0	0	(37,518)	22
23	Inservice Training & Education	(541)	0	0	0	0	0	0	0	0	0	0	(541)	23
24	Travel and Seminar	(983)	0	0	0	0	0	0	0	0	0	0	(983)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	97,456	0	0	0	0	0	0	0	0	0	0	97,456	26
27	Other (specify):*	(3,203)	3,203	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(37,203)	45,246	0	8,043	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(55,693)	(69,233)	0	(124,926)	29								

STATE OF ILLINOIS

Facility Name & ID Number VIP Manor

0038661

Report Period Beginning:

01/01/2005 Ending:

Summary B

12/31/2005

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(106,016)	0	0	0	0	0	0	0	0	0	0	(106,016)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	2	0	0	0	0	0	0	0	0	0	0	2	32
33	Real Estate Taxes	2,309	0	0	0	0	0	0	0	0	0	0	2,309	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(225)	(9)	0	0	0	0	0	0	0	0	0	(234)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(103,930)	(9)	0	(103,939)	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	(139,243)	0	0	0	0	0	0	0	0	0	0	(139,243)	39
40	Barber and Beauty Shops	(537)	0	0	0	0	0	0	0	0	0	0	(537)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	58,035	0	0	0	0	0	0	0	0	0	0	58,035	42
43	Other (specify):*	(42,433)	0	0	0	0	0	0	0	0	0	0	(42,433)	43
44	TOTAL Special Cost Centers	(124,178)	0	0	0	0	0	0	0	0	0	0	(124,178)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(283,801)	(69,242)	0	(353,043)	45								

Facility Name & ID Number VIP Manor

0038661

Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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
Beverly Health & Rehabilitation Services	100	More than 340 facilities throughout the U.S.		Aegis Therapies, Inc.	Fort Smith, AR	Therapy
				Ceres Strategies, Inc.	Fort Smith, AR	Purchasing
				AEDON Staffing, Inc.	Fort Smith, AR	Nursing Staffing
				CSMS, Inc.	Fort Smith, AR	Purchasing

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	017 Home Office Costs	\$ 295,253	Beverly Health & Rehabilitation Services	100.00%	\$ 337,296	\$ 42,043	1
2	V	010 Nursing Consultant	42,012	Beverly Health & Rehabilitation Services	100.00%	52,397	10,385	2
3	V	001 Dietary Consultant	0	Beverly Health & Rehabilitation Services	100.00%	2,329	2,329	3
4	V	012 Housekeeping Consultant	0	Beverly Health & Rehabilitation Services	100.00%	14	14	4
5	V							5
6	V	10a Therapy Expense/Home Office	393,893	Aegis Therapies, Inc.	100.00%	266,167	(127,726)	6
7	V	027 Home Office Costs	0	Ceres Strategies, Inc.	100.00%	3,203	3,203	7
8	V	021 Home Office Costs	0	Aedon Staffing, Inc.	100.00%	0		8
9	V	010 Home Office Costs	1,157	CSMS, Inc.	100.00%	1,338	181	9
10	V	002 Home Office Costs	2,160	CSMS, Inc.	100.00%	2,498	338	10
11	V	035 Home Office Costs	60	CSMS, Inc.	100.00%	51	(9)	11
12	V							12
13	V							13
14	Total		\$ 734,535			\$ 665,293	\$ * (69,242)	14

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

Facility Name & ID Number

VIP Manor

#

0038661

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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 VIP Manor

0038661

Report Period Beginning:

01/01/2005

Ending:

2/31/2005

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 Beverly Health & Rehabilitation Services
 Street Address One Thousand Beverly Way
 City / State / Zip Code Fort Smith, AR 72919
 Phone Number (479) 201-2000
 Fax Number (479) 201-4302

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	17	Corp Home Office/Admin	Resident Days	85,170	3	\$ 820,153	\$ 418,970	35,027	\$ 337,296	1
2										2
3										3
4	10	Corp QA Cost - Nursing	Resident Days	85,170	3	127,406	99,796	35,027	52,397	4
5										5
6	01	Corp QA Cost - Dietary	Resident Days	85,170	3	5,664	4,120	35,027	2,329	6
7										7
8	12	Corp QA Cost - Housekeeping	Resident Days	85,170	3	34	27	35,027	14	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					\$ 953,257	\$ 522,913		\$ 392,036	25

Facility Name & ID Number

VIP Manor

0038661

Report Period Beginning:

01/01/2005

Ending:

12/31/2005

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**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
	A. Directly Facility Related																
	Long-Term																
1							\$	\$			\$						
2																	
3																	
4																	
5																	
	Working Capital																
6	Non-Care Related Interest		X	Working Capital													
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. \$ 31,839 Line # 34

* 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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2004 report.		\$ 61,134	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.)		\$ 129,187	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 68,053	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 61,134	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.)		\$	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.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 129,187	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	2000	108,742	8
	2001	115,370	9
	2002	116,237	10
	2003	121,520	11
	2004	129,187	12
FOR OHF USE ONLY			
	13	FROM R. E. TAX STATEMENT FOR 2004 \$	13
	14	PLUS APPEAL COST FROM LINE 5 \$	14
	15	LESS REFUND FROM LINE 6 \$	15
	16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME VIP Manor COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0038661

CONTACT PERSON REGARDING THIS REPORT Greg LeRoy

TELEPHONE (479) 201-4371 FAX #: (479) 201-4302

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 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 2004.

(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. <u>19-2-08-22-14-302-011</u>	<u>Encore VIP Manor IL LLC.</u>	<u>\$ 129,187.00</u>	<u>\$ 129,187.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	TOTALS	\$ 129,187.00	\$ 129,187.00

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 X NO

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

C. Tax Bills

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number VIP Manor

0038661 Report Period Beginning:

01/01/2005 Ending:

12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,000 B. General Construction Type: Exterior Brick Frame Concrete 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>Facility</u>		<u>1985</u>	\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number VIP Manor

0038661

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	106		1985		\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10		LEASEHOLD IMPROVEMENTS		1993	59,410	1,545	5-20	1,545		55,415	10
11		(See depreciation schedule for asset detail of items acquired 1993 - 2001)		1994	87,778	846	5-20	846		80,834	11
12				1995	165,318	10,093	5-20	10,093		122,909	12
13				1996	2,061	72	5-20	72		1,638	13
14				1997	56,806	4,764	5-20	4,764		48,728	14
15				1998	20,995	1,361	5-20	1,361		11,653	15
16				1999	11,194	925	5-20	925		5,972	16
17				2000	63,678	5,396	5-20	5,396		32,464	17
18				2001	30,318	3,127	5-20	3,127		14,583	18
19											19
20		DOOR W/FRAME-DINING ROOM		2002	760	76	10	76		279	20
21		CONSTRUCTION INTEREST		2002	912	61	15	61		213	21
22		FIXED EQUIPMENT-15 YEAR LIFE		2002	32,296	2,153	15	2,153		7,536	22
23		REPL CONDENSOR/2DR COOLER		2002	920	61	15	61		194	23
24											24
25											25
26											26
27											27
28											28
29		CONTRACTOR PAY REQUESTS		2003	6,113	408	15	408		1,155	29
30		2 KEYPADS		2003	824	55	15	55		142	30
31		2.5TON CENTRAL AIR UNIT		2003	2,817	563	5	563		1,409	31
32		THERMO MIXING VALVE,MIX CA		2003	1,777	118	15	118		266	32
33		3.5 TON UNIT/NORTH WING		2003	2,817	563	5	563		1,268	33
34		7.5 TON UNIT/DIETARY		2003	6,380	638	10	638		1,436	34
35		2 DROPS		2003	525	35	15	35		73	35
36											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 VIP Manor

0038661

Report Period Beginning:

01/01/2005 Ending: 12/31/2005

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	1ST PMT/FIRE WALLS & DOORS	2004	\$ 3,000	\$ 300	10	\$ 300	\$	\$ 550	37
38	1 DELAY EGRESS MAG LOCK,IN	2004	1,001	100	10	100		184	38
39	FIRE WALLS ABOVE FIRE DOOR	2004	10,000	1,000	10	1,000		1,833	39
40	3RD PMT:LABOR/MATERIALS	2004	2,643	264	10	264		463	40
41	2.5TON ROOFTOP UNIT,INSTALL	2004	2,875	575	5	575		910	41
42	3TON ROOFTOP UNIT, INSTALL	2004	2,994	599	5	599		898	42
43	INSTL 2 ADDL FIRE WALLS	2004	6,000	600	10	600		900	43
44	REPL CARPET FRONT LOBBY	2004	3,953	791	5	791		988	44
45	CONSTRUCTION INTEREST	2004	1,477	98	15	98		123	45
46	FIXED EQUIPMENT-15 YEAR LIFE	2004	65,000	4,333	15	4,333		5,417	46
47	CONTRACTOR PAY REQUESTS	2004	563	38	15	38		47	47
48	ARCHITECTURAL FEES	2004	17,849	1,190	15	1,190		1,487	48
49	RECEPTACLES,CIRCUITS,INSTL	2004	1,371	69	20	69		86	49
50									50
51	PAINTING 12 UNITS	2005	1,800	360	5	360		360	51
52	PAINTING 12 UNITS 400 HALL	2005	1,800	360	5	360		360	52
53	DEPOSIT:3 WATER HEATER REP	2005	24,150	2,214	10	2,214		2,214	53
54	PAINTING/11 UNITS	2005	1,650	303	5	303		303	54
55	PAINT	2005	930	170	5	170		170	55
56	PAINTING 11 UNITS	2005	1,650	303	5	303		303	56
57	2 EXHAUST FANS, INSTALL	2005	2,830	173	15	173		173	57
58	1 DROP	2005	505	28	15	28		28	58
59	2 DROPS	2005	688	38	15	38		38	59
60	PAINTING/8 UNITS	2005	1,200	200	5	200		200	60
61	ELECTRICAL INSTALLATION	2005	4,644		1.666667				61
62	WATER HEATERS,INSTL/BALANC	2005	11,956		1.666667				62
63	A/C COMPRESSOR, INSTALL	2005	991		1.416667				63
64	3TON A/C UNIT, INSTALL	2005	2,810		1.25				64
65	DISPOSAL	2005	895		1.166667				65
66	1 DROP	2005	525		1.166667				66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 731,448	\$ 46,966		\$ 46,966	\$	\$ 406,200	70

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

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

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	\$ 324,592	\$ 23,469	\$ 23,469	\$	5-10	\$ 227,946	71
72	Current Year Purchases	28,300	577	577		5-10	577	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 352,892	\$ 24,046	\$ 24,046	\$		\$ 228,523	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$ 1,084,340	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 71,012	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 71,012	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 634,723	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.

Facility Name & ID Number VIP Manor

0038661

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Encore Retirement Centers, Inc.

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:		106	12/31/1985	\$ 575,334	5	30	3
4	Additions							4
5								5
6								6
7	TOTAL		106		\$ 575,334			7

10. Effective dates of current rental agreement:

Beginning 12/31/2001

Ending 12/31/2006

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

Fiscal Year Ending Annual Rent

12. 12/31/2006 \$ 516,518

13. _____ \$ _____

14. _____ \$ _____

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: Purchase of all Encore facilities *

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: See attached schedule

(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	Facility	2001 Chevrolet E-350	\$ 701.58	\$ 8,419	17
18					18
19					19
20					20
21	TOTAL		\$ 701.58	\$ 8,419	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.

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	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	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 VIP Manor# 0038661Report Period Beginning: 01/01/2005

Ending:

12/31/2005**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2005

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,750	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>63,209</u>)	600,556		3
4	Supply Inventory (priced at <u>Historical Cost</u>)	18,496		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	85,512		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 707,314	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	112,435		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	731,448		15
16	Equipment, at Historical Cost	352,892		16
17	Accumulated Depreciation (book methods)	(634,723)		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)	\$ 562,052	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,269,366	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 77,697	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	81,977		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,571		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,109		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued Contingencies</u>			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 228,354	\$	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	<u>Intercompany</u>	716,956		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 716,956	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 945,310	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 324,056	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,269,366	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,148,036	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,148,036	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(823,980)	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)	\$ (823,980)	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)	\$ 324,056	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number VIP Manor

0038661

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

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	\$ 4,618,489	1
2	Discounts and Allowances for all Levels	(606,764)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,011,725	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	523,266	6
7	Oxygen	9,085	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 532,351	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	1,750	13
14	Non-Patient Meals	6,833	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	109,933	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	24,084	19
20	Radiology and X-Ray	1,319	20
21	Other Medical Services	36,671	21
22	Laundry	4,710	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 185,300	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Net Vending, Pat Pers Needs, Other Misc. Rev	3,210	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,210	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,732,586	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	723,650	31
32	Health Care	2,482,888	32
33	General Administration	1,268,585	33
B. Capital Expense			
34	Ownership	913,757	34
C. Ancillary Expense			
35	Special Cost Centers	109,651	35
36	Provider Participation Fee	58,035	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,556,566	40
41	Income before Income Taxes (line 30 minus line 40)**	(823,980)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (823,980)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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 VIP Manor

0038661

Report Period Beginning: 01/01/2005

Ending:

12/31/2005

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,016	2,160	\$ 70,791	\$ 32.77	1
2	Assistant Director of Nursing	1,778	1,800	55,458	30.80	2
3	Registered Nurses	20,766	22,179	479,751	21.63	3
4	Licensed Practical Nurses	17,915	18,521	407,878	22.02	4
5	CNAs & Orderlies	67,606	71,245	728,033	10.22	5
6	CNA Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	0	0	0		9
10	Activity Assistants	3,770	4,195	43,926	10.47	10
11	Social Service Workers	4,152	4,300	49,368	11.48	11
12	Dietician	398	398	8,773	22.07	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	16,553	17,993	137,172	7.62	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,278	2,358	37,779	16.02	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	2,768	2,896	92,041	31.78	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	10,016	11,228	143,973	12.82	22
23	Office Manager	0	0	0		23
24	Clerical	0	0	0		24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	0	0	0		31
32	Other Health Care MDS Coordinator	1,800	1,888	38,650	20.47	32
33	Other(specify) DSD Coordinator	510	526	12,329	23.44	33
34	TOTAL (lines 1 - 33)	152,326	161,685	\$ 2,305,922 *	\$ 14.26	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		\$ 203	1-3	35
36	Medical Director		18,000	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		7,115	10-3	39
40	Physical Therapy Consultant		129,550	10a-3	40
41	Occupational Therapy Consultant		119,891	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		16,726	10a-3	43
44	Activity Consultant		1,346	11-3	44
45	Social Service Consultant		3,092	12-3	45
46	Other(specify) <u>Hskpg/Laundry</u>		151,232	3,4	46
47	<u>Maintenance, Other Admin, Lab</u>		46,981	6	47
48	<u>Profess,MedWaste, Transport</u>		972	6,19	48
49	TOTAL (lines 35 - 48)		\$ 495,108		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$3,922
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (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? _____
- (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? Various
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,766 Line 10
- (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. _____
- (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. \$ 58,035
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. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 6,833
- (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? 50%
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? Yes
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. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ernst & Young, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Beverly is a publicly traded company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.