

Facility Name & ID Number VIP Manor

0038661 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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				
		Medicaid		Other	Total	
		Recipient	Private Pay			
8	SNF	2,834	5,650	3,883	12,367	8
9	SNF/PED					9
10	ICF	22,472			22,472	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	25,306	5,650	3,883	34,839	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.05%

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

42 (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 3,881

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: 12/31/2006 Fiscal Year: 12/31/2006

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

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

	Operating Expenses	Costs Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	190,900	13,196	1,131	205,227		205,227	6,567	211,794		1
2	Food Purchase		165,405		165,405		165,405	(4,795)	160,610		2
3	Housekeeping		57	95,128	95,185		95,185		95,185		3
4	Laundry		13,505	63,419	76,924		76,924		76,924		4
5	Heat and Other Utilities			106,429	106,429		106,429	2,201	108,630		5
6	Maintenance	32,574	9,501	46,980	89,055		89,055	1,381	90,436		6
7	Other (specify):*			2,718	2,718		2,718		2,718		7
8	TOTAL General Services	223,474	201,664	315,805	740,943		740,943	5,354	746,297		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,856,076	105,871	178,014	2,139,961	(10,751)	2,129,210	(37,904)	2,091,306		10
10a	Therapy		793	544,300	545,093	(790)	544,303	(71,172)	473,131		10a
11	Activities	43,390	3,313	797	47,500		47,500	54	47,554		11
12	Social Services	34,175	13	3,997	38,185		38,185	(310)	37,875		12
13	CNA Training										13
14	Program Transportation			6,953	6,953		6,953	90	7,043		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,933,641	109,990	752,061	2,795,692	(11,541)	2,784,151	(109,242)	2,674,909		16
	C. General Administration										
17	Administrative			345,725	345,725	75,029	420,754	(251,898)	168,856		17
18	Directors Fees										18
19	Professional Services			18,495	18,495		18,495	(5,475)	13,020		19
20	Dues, Fees, Subscriptions & Promotions			30,851	30,851		30,851	(9,724)	21,127		20
21	Clerical & General Office Expenses	111,421	23,720	220,921	356,062	(74,428)	281,634	43,068	324,702		21
22	Employee Benefits & Payroll Taxes			442,041	442,041		442,041	(24,454)	417,587		22
23	Inservice Training & Education			3,735	3,735		3,735	151	3,886		23
24	Travel and Seminar			15,409	15,409	(875)	14,534	(1,333)	13,201		24
25	Other Admin. Staff Transportation			2,385	2,385		2,385		2,385		25
26	Insurance-Prop.Liab.Malpractice			123,145	123,145		123,145	(7,412)	115,733		26
27	Other (specify):*										27
28	TOTAL General Administration	111,421	23,720	1,202,707	1,337,848	(274)	1,337,574	(257,077)	1,080,497		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,268,536	335,374	2,270,573	4,874,483	(11,815)	4,862,668	(360,965)	4,501,703		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:

01/01/2006

Ending:

12/31/2006

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			515,942	515,942		515,942	(428,826)	87,116			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(144)	(144)		(144)	144				32
33	Real Estate Taxes			137,027	137,027		137,027	(8,871)	128,156			33
34	Rent-Facility & Grounds			580,634	580,634		580,634		580,634			34
35	Rent-Equipment & Vehicles			49,258	49,258	3,113	52,371	4,995	57,366			35
36	Other (specify):*			602,310	602,310		602,310	(602,310)				36
37	TOTAL Ownership			1,885,027	1,885,027	3,113	1,888,140	(1,034,868)	853,272			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		88,091	125	88,216	571	88,787	(88,787)				39
40	Barber and Beauty Shops			145	145		145	(145)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							57,876	57,876			42
43	Other (specify):*		10,174	20,251	30,425	8,131	38,556	(38,556)				43
44	TOTAL Special Cost Centers		98,265	20,521	118,786	8,702	127,488	(69,612)	57,876			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,268,536	433,639	4,176,121	6,878,296		6,878,296	(1,465,445)	5,412,851			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:

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Ending:

12/31/2006

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	(7,693)	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	(133)	2		13
14	Non-Care Related Interest	144	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	(22,880)	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	(148,140)	21		24
25	Fund Raising, Advertising and Promotional	(12,088)	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	(1,173,954)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,364,744)		\$	30

BHF USE ONLY						
48		49		50		51
						52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(83,462)	17	34
35	Other- Attach Schedule	(17,239)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (100,701)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,465,445)		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

VIP Manor

ID# 0038661

Report Period Beginning: 01/01/2006

Ending: 12/31/2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Sch V	Adj. Summary
Line 1	0
Line 2	(7,826)
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	(7,826)
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	(83,462)
Line 18	0
Line 19	0
Line 20	(12,088)
Line 21	(148,140)
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	(22,880)
Line 28	(266,570)
Line 29	(274,396)
Line 30	0
Line 31	0
Line 32	144
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	144
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(274,252)

STATE OF ILLINOIS

Summary A

Facility Name & ID Number VIP Manor# 0038661 Report Period Beginning:

01/01/2006

Ending: 12/31/2006

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	2,256	4,311	0	0	0	0	0	0	0	0	0	6,567	1
2	Food Purchase	(4,950)	155	0	0	0	0	0	0	0	0	0	(4,795)	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	2,201	0	0	0	0	0	0	0	0	0	0	2,201	5
6	Maintenance	1,381	0	0	0	0	0	0	0	0	0	0	1,381	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	888	4,466	0	5,354	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	(32,431)	(5,473)	0	0	0	0	0	0	0	0	0	(37,904)	10
10a	Therapy	0	(71,172)	0	0	0	0	0	0	0	0	0	(71,172)	10a
11	Activities	54	0	0	0	0	0	0	0	0	0	0	54	11
12	Social Services	(310)	0	0	0	0	0	0	0	0	0	0	(310)	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	(32,597)	(76,645)	0	(109,242)	16								
	C. General Administration													
17	Administrative	(373,860)	121,962	0	0	0	0	0	0	0	0	0	(251,898)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,475)	0	0	0	0	0	0	0	0	0	0	(5,475)	19
20	Fees, Subscriptions & Promotions	(9,724)	0	0	0	0	0	0	0	0	0	0	(9,724)	20
21	Clerical & General Office Expenses	181,303	(138,235)	0	0	0	0	0	0	0	0	0	43,068	21
22	Employee Benefits & Payroll Taxes	(24,454)	0	0	0	0	0	0	0	0	0	0	(24,454)	22
23	Inservice Training & Education	151	0	0	0	0	0	0	0	0	0	0	151	23
24	Travel and Seminar	(1,333)	0	0	0	0	0	0	0	0	0	0	(1,333)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(7,412)	0	0	0	0	0	0	0	0	0	0	(7,412)	26
27	Other (specify):* <u>Purchasing Exper</u>	(4,990)	4,990	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(245,794)	(11,283)	0	(257,077)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(277,503)	(83,462)	0	(360,965)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number VIP Manor

0038661

Report Period Beginning:

01/01/2006 Ending:

12/31/2006

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	(428,826)	0	0	0	0	0	0	0	0	0	0	(428,826) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	144	0	0	0	0	0	0	0	0	0	0	144 32
33	Real Estate Taxes	(8,871)	0	0	0	0	0	0	0	0	0	0	(8,871) 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	4,995	0	0	0	0	0	0	0	0	0	0	4,995 35
36	Other (specify):* Loss sold facility	(602,310)	0	0	0	0	0	0	0	0	0	0	(602,310) 36
37	TOTAL Ownership	(1,034,868)	0	0	0	0	0	0	0	0	0	0	(1,034,868) 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	(88,787)	0	0	0	0	0	0	0	0	0	0	(88,787) 39
40	Barber and Beauty Shops	(145)	0	0	0	0	0	0	0	0	0	0	(145) 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	57,876	0	0	0	0	0	0	0	0	0	0	57,876 42
43	Other (specify):* Lab, Xray, suppli	(38,556)	0	0	0	0	0	0	0	0	0	0	(38,556) 43
44	TOTAL Special Cost Centers	(69,612)	0	0	0	0	0	0	0	0	0	0	(69,612) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(1,381,983)	(83,462)	0	(1,465,445) 45								

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	54 facilities throughout the U.S.		Aegis Therapies, Inc.	Fort Smith, AR	Therapy
				Ceres Strategies, Inc.	Fort Smith, AR	Purchasing
				AEDON Staffing, LLC	Fort Smith, AR	Staffing
				CSMS, LLC	Fort Smith, AR	Purchasing
				Golden Ventures	Fort Smith, AR	General Services

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:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	017 General Services	\$ 201,759	BHRS/Golden Ventures	100.00%	\$ 323,721	\$ 121,962	1
2	V	010 Nursing Consultant	51,287	BHRS/Golden Ventures	100.00%	45,560	(5,727)	2
3	V	001 Dietary Consultant	0	BHRS/Golden Ventures	100.00%	4,311	4,311	3
4	V	012 Housekeeping Consultant	0	BHRS/Golden Ventures	100.00%	0		4
5	V	021 General Services	132,798	BHRS/Golden Ventures	100.00%		(132,798)	5
6	V	10a Therapy Expense	544,300	Aegis Therapies, Inc.	100.00%	473,128	(71,172)	6
7	V	027 Purchasing Expense	0	Ceres Strategies, Inc.	100.00%	4,990	4,990	7
8	V	021 Staffing	73,276	Aedon Staffing, LLC	100.00%	67,839	(5,437)	8
9	V	010 Purch/Supplies	1,534	CSMS, LLC	100.00%	1,788	254	9
10	V	002 Purch/Supplies	1,125	CSMS, LLC	100.00%	1,280	155	10
11	V	035 Purch/Supplies	0	CSMS, LLC	100.00%	0		11
12	V							12
13	V							13
14	Total		\$ 1,006,079			\$ 922,617	\$ * (83,462)	14

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

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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: 01/01/2006

Ending: 2/31/2006

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 BHRS, Golden Ventures
 Street Address 1000 Fianna 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	17,21	General Services	Resident Days	84,763	3	\$ 786,822	\$ 160,467	34,881	\$ 323,787	1
2										2
3										3
4	10	QA Cost - Nursing	Resident Days	84,763	3	110,751	13,641	34,881	45,575	4
5										5
6	01	QA Cost - Dietary	Resident Days	84,763	3	10,460	1,268	34,881	4,304	6
7										7
8	12	QA Cost - Housekeeping	Resident Days	84,763	3	0	0	34,881	0	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		ROUNDING							(74)	24
25	TOTALS					\$ 908,033	\$ 175,376		\$ 373,592	25

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 01/01/2006 Ending: 12/31/2006

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

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

		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 2005 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.)		\$ 128,156	2
3.	Under or (over) accrual (line 2 minus line 1).		\$ 67,022	3
4.	Real Estate Tax accrual used for 2006 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.		\$ 128,156	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
	2001	115,370	8	
	2002	116,237	9	
	2003	121,520	10	
	2004	129,187	11	
	2005	128,156	12	
FOR BHF USE ONLY				
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	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: 2005 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 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 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,

2005 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 Costs

Enter the tax index number and real estate tax assessed for 2005 on the lines provided below. Enter only the portion of total 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 2005.

(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>\$ 128,156.00</u>	<u>\$ 128,156.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		<u>\$ 128,156.00</u>	<u>\$ 128,156.00</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006

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 VIP Manor# 0038661 Report Period Beginning:01/01/2006 Ending: 12/31/2006**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 30,132 B. General Construction Type: Exterior Brick Frame Concrete Number of Stories OneC. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1985	\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	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		56,960
11	(See depreciation schedule for asset detail of items acquired 1993 - 2002)		1994	87,778	846	5-20	846		81,680
12			1995	165,318	9,989	5-20	9,989		132,898
13			1996	2,061	72	5-20	72		1,711
14			1997	56,806	4,764	5-20	4,764		53,492
15			1998	20,995	1,361	5-20	1,361		13,013
16			1999	11,194	925	5-20	925		6,896
17			2000	63,678	5,266	5-20	5,266		37,730
18			2001	30,318	2,932	5-20	2,932		17,515
19			2002	34,888	2,351	5-20	2,351		10,573
20									20
21	CONTRACTOR PAY REQUESTS		2003	6,113	408	15	408		1,562
22	2 KEYPADS		2003	824	55	15	55		197
23	2.5 TON CENTRAL AIR UNIT		2003	2,817	563	5	563		1,972
24	THERMO MIXING VALVE,MIX CA		2003	1,777	118	15	118		385
25	3.5 TON UNIT/NORTH WING		2003	2,817	563	5	563		1,831
26	7.5 TON UNIT/DIETARY		2003	6,380	638	10	638		2,074
27	2 DROPS		2003	525	35	15	35		108
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									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:

01/01/2006 Ending: 12/31/2006

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	\$	\$ 850		37
38	1 DELAY EGRESS MAG LOCK,IN	2004	1,001	100	10	100		284		38
39	FIRE WALLS ABOVE FIRE DOOR	2004	10,000	1,000	10	1,000		2,833		39
40	3RD PMT:LABOR/MATERIALS	2004	2,643	264	10	264		727		40
41	2.5TON ROOFTOP UNIT,INSTAL	2004	2,875	575	5	575		1,485		41
42	3TON ROOFTOP UNIT, INSTALL	2004	2,994	599	5	599		1,497		42
43	INSTL 2 ADDL FIRE WALLS	2004	6,000	600	10	600		1,500		43
44	REPL CARPET FRONT LOBBY	2004	3,953	791	5	791		1,779		44
45	CONSTRUCTION INTEREST	2004	1,477	98	15	98		222		45
46	FIXED EQUIPMENT-15 YEAR LIFE	2004	65,000	4,333	15	4,333		9,750		46
47	CONTRACTOR PAY REQUESTS	2004	563	38	15	38		84		47
48	ARCHITECTURAL FEES	2004	17,849	1,190	15	1,190		2,677		48
49	RECEPTACLES,CIRCUITS,INSTL	2004	1,371	69	20	69		154		49
50										50
51	PAINTING 12 UNITS	2005	1,800	360	5	360		720		51
52	PAINTING 12 UNITS 400 HALL	2005	1,800	360	5	360		720		52
53	DEPOSIT:3 WATER HEATER REP	2005	24,150	2,415	10	2,415		4,629		53
54	PAINTING/11 UNITS	2005	1,650	330	5	330		633		54
55	PAINT	2005	930	186	5	186		356		55
56	PAINTING 11 UNITS	2005	1,650	330	5	330		633		56
57	2 EXHAUST FANS, INSTALL	2005	2,830	189	15	189		362		57
58	1 DROP	2005	505	34	15	34		62		58
59	2 DROPS	2005	688	46	15	46		84		59
60	PAINTING/8 UNITS	2005	1,200	240	5	240		440		60
61	ELECTRICAL INSTALLATION	2005	4,644	232	20	232		387		61
62	WATER HEATERS,INSTL/BALANC	2005	11,956	797	15	797		1,328		62
63	A/C COMPRESSOR, INSTALL	2005	991	198	5	198		281		63
64	3TON A/C UNIT, INSTALL	2005	2,810	562	5	562		703		64
65	DISPOSAL	2005	895	179	5	179		209		65
66	1 DROP	2005	525	35	15	35		41		66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 731,448	\$ 48,881		\$ 48,881	\$	\$ 456,025		70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 731,448	\$ 48,881		\$ 48,881	\$	\$ 456,025	1
2									2
3	ROOF REPAIR	2006	275,394	13,770	10	13,770		13,770	3
4	CONSTRUCTION INTEREST	2006	2,710	90	15	90		90	4
5	12 EMERGENCY LIGHTS	2006	584	24	10	24		24	5
6	CIRCULATOR PUMP/BOILER/INS	2006	1,082	30	15	30		30	6
7	BACKFLOW PREVENTOR.INSTALL	2006	7,036	195	15	195		195	7
8	CONTROL BOARD.KEYPAD.INSTL	2006	1,647	18	15	18		18	8
9	4 HEAT/SMOKE DETECTORS	2006	520	9	5	9		9	9
10	BACKFLOW PREVENTOR.INSTALL	2006	3,691	246	15	246		246	10
11	DROPS	2006	1,363	8	15	8		8	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	TOTAL (lines 1 thru 33)		\$ 1,025,475	\$ 63,271		\$ 63,271	\$	\$ 470,416	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 353,072	\$ 22,856	\$ 22,856	\$	5-10	\$ 255,879	71
72	Current Year Purchases	17,842	989	989		5-10	989	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 370,914	\$ 23,845	\$ 23,845	\$		\$ 256,868	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)	\$ 1,396,389	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 87,116	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 87,116	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)	\$ 727,284	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: 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*	7
3	Original Building:	106	12/31/1985	\$ 580,634	5	30	3
4	Additions						4
5							5
6							6
7	TOTAL	106		\$ 580,634			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. _____	\$ _____
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	\$ 301.00	\$ 3,612	17
18					18
19					19
20					20
21	TOTAL		\$ 301.00	\$ 3,612	21

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)		Units	Cost						
			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.

STATE OF ILLINOIS

Facility Name & ID Number VIP Manor # 0038661 Report Period Beginning: 01/01/2006 Ending: 12/31/2006
 XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2006 (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	\$ 5,659	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 148,312)	1,049,889		3
4	Supply Inventory (priced at Historical Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	109,416		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Cash to/from facility	(1,603,995)		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (439,031)	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable	126,047		11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,025,475		15
16	Equipment, at Historical Cost	370,914		16
17	Accumulated Depreciation (book methods)	(727,284)		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)	\$ 795,152	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 356,121	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 390,205	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,787		30
31	Accrued Taxes Payable (excluding real estate taxes)	43,041		31
32	Accrued Real Estate Taxes(Sch.IX-B)	61,134		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36		11,700		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 599,867	\$	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	Intercompany			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 599,867	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (243,746)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 356,121	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 324,056	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 324,056	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(2,002,907)	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)	\$ (2,002,907)	17
B. Transfers (Itemize):			
18	Adjustments related to sale of company	1,435,105	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 1,435,105	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (243,746)	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Facility Name & ID Number VIP Manor

0038661

Report Period Beginning: 01/01/2006

Ending:

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12/31/2006

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	\$ 4,640,012	1
2	Discounts and Allowances for all Levels	(769,627)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,870,385	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	809,369	6
7	Oxygen	26	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 809,395	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	1,314	13
14	Non-Patient Meals	7,693	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	85,511	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	56,654	19
20	Radiology and X-Ray	669	20
21	Other Medical Services	41,177	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 193,018	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	2,591	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,591	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,875,389	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	740,943	31
32	Health Care	2,795,692	32
33	General Administration	1,337,848	33
B. Capital Expense			
34	Ownership	1,885,027	34
C. Ancillary Expense			
35	Special Cost Centers	60,910	35
36	Provider Participation Fee	57,876	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,878,296	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,002,907)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,002,907)	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: 01/01/2006

Ending: 12/31/2006

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	1,416	2,096	\$ 76,392	\$ 36.45	1
2	Assistant Director of Nursing	3,369	3,888	93,462	24.04	2
3	Registered Nurses	10,140	10,785	236,232	21.90	3
4	Licensed Practical Nurses	24,073	24,845	535,017	21.53	4
5	CNAs & Orderlies	67,986	71,837	771,706	10.74	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	3,715	4,041	43,391	10.74	10
11	Social Service Workers	3,007	3,103	34,098	10.99	11
12	Dietician	308	308	7,000	22.76	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	17,243	18,678	150,460	8.06	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,772	1,974	32,475	16.45	17
18	Housekeepers	0	0	0		18
19	Laundry	0	0	0		19
20	Administrator	1,720	1,840	75,029	40.78	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	6,469	7,076	96,987	13.71	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(specify)	4,000	4,259	92,261	21.66	32
33	Other(specify)	864	924	24,026	26.00	33
34	TOTAL (lines 1 - 33)	146,081	155,654	\$ 2,268,536 *	\$ 14.57	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	\$ 1,123	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	6,174	10-3	39
40	Physical Therapy Consultant	188,391	10a-3	40
41	Occupational Therapy Consultant	194,975	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	89,762	10a-3	43
44	Activity Consultant	796	11-3	44
45	Social Service Consultant	3,997	12-3	45
46	Other(specify)	158,547	3,4	46
47	Maintenance,Other Admin, Lab	81,790	6	47
48	Profess,MedWaste,Transport	920	6,19	48
49	TOTAL (lines 35 - 48)	\$ 744,475		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	\$ 312	14,052	10-3	50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)	312	\$ 14,052		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 \$4,012
- (3) Did the nursing home make political contributions or payments to a political 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. \$ 26,734 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. \$ 57,876
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,693
- (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. BEI is audited as a whole.
- (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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Facility	VIP MANOR	IDPH ID	0038661	BEI FACILITY	03924
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2006 Illinois Medicaid Cost Report

Travel Detail (Schedule V, Line 24)

For the Period Ending December 31, 2006

Facility	IDPH ID	Employee Name	Destination	Reason for Travel	Description	Mileage	Mileage Rate	Mileage Reimbursement	Other Amount	Account	Date
03924	0038661	Brooke Vogel	Chicago, IL	Regional Conference	Expense includes lodging				366.97	7612000570	2006-01
03924	0038661	Brooke Vogel	Chicago, IL	Regional Conference.	Expense includes food expense.				371.82	7614000570	2006-01
03924	0038661	Rod Hirschert	Wood River, IL	Working at VIP Manor	Expense includes lodging	590	\$0.340	200.60	107.81	7612000570	2006-05
03924	0038661	Mary Garcia	IL - various	Referrals, visiting DC planners, visiting residents in hospital		745	\$0.390	290.55		7612000570	2006-06
03924	0038661	Mary Garcia	IL - various	Referrals, visiting DC planners, visiting residents in hospital		664	\$0.390	258.96		7612000570	2006-06
03924	0038661	Rod Hirschert	Godfrey, Wood River, IL	Visit facilities VIP Manor & Blu Fountain		684	\$0.340	232.56	177.48	7612000570	2006-06
03924	0038661	Rod Hirschert	Wood River, IL	Assisting during power outage at VIP Manor	Expense includes lodging	830	\$0.410	340.30	595.08	7612000570	2006-07
03924	0038661	Mary Garcia	IL - various	Referrals, visiting DC planners, visiting residents in hospital		612	\$0.410	250.92		7612000570	2006-07
03924	0038661	Rod Hirschert	Godfrey, Wood River, IL	Visit facilities VIP Manor & Blu Fountain		564	\$0.410	231.24	23.89	7612000570	2006-08
03924	0038661	Mary Garcia	IL - various	Visit DC planners/residents in hospital		633	\$0.410	259.53		7612000570	2006-08
03924	0038661	Mary Garcia	IL - various	Visit DC planners, referrals		654	\$0.410	268.14		7612000570	2006-08
03924	0038661	Mary Garcia	IL - various	Referrals, visiting DC planners, visiting residents in hospital		611	\$0.410	250.51		7612000570	2006-09
03924	0038661	Mary Garcia	DePaul, Barnes, various	Referrals, visiting DC planners, visiting residents in hospital		627	\$0.410	257.07		7612000570	2006-08
03924	0038661	Ken Evans	Wood River, IL	Assist VIP Manor	Expense includes lodging, car rental, meals				1,090.68	7612000570	2006-09
03924	0038661	ADJUSTMENTS							(303)		

All Other Amounts < \$250

7,930

Totals									2,840	10,361
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Facility	VIP MANOR	IDPH ID	0038661			BHRS FACILITY	03924
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2006 Illinois Medicaid Cost Report
 Other Admin Staff Transpotation (Schedule V, Line 25)
 For the Period Ending December 31, 2006

Facility	IDPH ID	Vendor	Description	Amount	Account	Department		
03924	0038661	DL Peterson Trust/ PHH	Fuel and Oil Expense	2,385	7616	900		
03924	0038661	ADJUSTMENTS						

Totals				2385				
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