

		FOR BHF USE					

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**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.

<p><b>I. IDPH Facility ID Number:</b> <u>0039289</u></p> <p><b>Facility Name:</b> <u>Pine Acres Care Center</u></p> <p><b>Address:</b> <u>1212 S. Second Street</u> <u>De Kalb</u> <u>60115</u>  <small>Number City Zip Code</small></p> <p><b>County:</b> <u>De Kalb</u></p> <p><b>Telephone Number:</b> <u>815-758-8151</u> Fax # <u>815-758-6832</u></p> <p><b>HFS ID Number:</b> <u>36-2166970-005</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>03/01/1994</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td style="width:33%; border: none;"><input type="checkbox"/> PROPRIETARY</td> <td style="width:33%; border: none;"><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td style="border: none;"><input checked="" type="checkbox"/> Charitable Corp.</td> <td style="border: none;"><input type="checkbox"/> Individual</td> <td style="border: none;"><input type="checkbox"/> State</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"><input type="checkbox"/> Partnership</td> <td style="border: none;"><input type="checkbox"/> County</td> </tr> <tr> <td style="border: none;"><b>IRS Exemption Code</b> <u>501©3</u></td> <td style="border: none;"><input type="checkbox"/> Corporation</td> <td style="border: none;"><input type="checkbox"/> Other _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> "Sub-S" Corp.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Limited Liability Co.</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Trust</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;"><input type="checkbox"/> Other _____</td> <td style="border: none;"></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Donald Primdahl</u> <b>Telephone Number:</b> <u>630-521-8034</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> <u>501©3</u>	<input 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 _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/04</u> to <u>06/30/05</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;"><b>Officer or Administrator of Provider</b></td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Type or Print Name) <u>Thomas L. Noesen, Jr.</u></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Title) <u>Treasurer</u></td> <td style="border: none;"></td> </tr> </table> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;"><b>Paid Preparer</b></td> <td style="border: none;">(Signed) _____</td> <td style="border: none;">(Date) _____</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Print Name and Title) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Firm Name &amp; Address) _____</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">(Telephone) (____) _____</td> <td style="border: none;">Fax # (____) _____</td> </tr> </table> <p align="center"> <b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>        201 S. Grand Avenue East        Springfield, IL 62763-0001 <span style="float: right;">Phone # (217) 782-1630</span> </p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Date) _____		(Type or Print Name) <u>Thomas L. Noesen, Jr.</u>			(Title) <u>Treasurer</u>		<b>Paid Preparer</b>	(Signed) _____	(Date) _____		(Print Name and Title) _____			(Firm Name & Address) _____			(Telephone) (____) _____	Fax # (____) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																																												
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Facility Name & ID Number Pine Acres Care Center

# 0039289 Report Period Beginning: 07/01/04 Ending: 06/30/05

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	119	Skilled (SNF)	119	43,435	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	119	TOTALS	119	43,435	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	12,963	15,590	2,296	30,849	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,963	15,590	2,296	30,849	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.02%

D. How many bed-hold days during this year were paid by the Department? None (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)

Staff Food Service

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 03/01/1994

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date \_\_\_\_\_ NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 8 and days of care provided 2,296

Medicare Intermediary Adminastar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 06/30/05 Fiscal Year: 06/30/05  
\* All facilities other than governmental must report on the accrual basis.

Facility Name &amp; ID Number

Pine Acres Care Center

# 0039289

Report Period Beginning:

07/01/04

Ending:

06/30/05

## 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
	<b>A. General Services</b>										
1	Dietary	262,915	6,505	5,276	274,696	2,647	277,343		277,343		1
2	Food Purchase		190,372		190,372		190,372	(7,299)	183,073		2
3	Housekeeping	131,026	28,840	100	159,966		159,966		159,966		3
4	Laundry			88,276	88,276		88,276		88,276		4
5	Heat and Other Utilities			98,831	98,831		98,831		98,831		5
6	Maintenance	43,921	28,794	31,760	104,475	67	104,542		104,542		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	437,862	254,511	224,243	916,616	2,714	919,330	(7,299)	912,031		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,800	9,800		9,800		9,800		9
10	Nursing and Medical Records	1,542,604	315,976	53,758	1,912,338	(148,800)	1,763,538		1,763,538		10
10a	Therapy	49,213	86	118,165	167,464		167,464		167,464		10a
11	Activities	71,035	952	5,076	77,063	245	77,308		77,308		11
12	Social Services	73,138		6,975	80,113		80,113		80,113		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,735,990	317,014	193,774	2,246,778	(148,555)	2,098,223		2,098,223		16
	<b>C. General Administration</b>										
17	Administrative	77,671			77,671	88,951	166,622		166,622		17
18	Directors Fees										18
19	Professional Services			597,701	597,701	(112,505)	485,196	(357,882)	127,314		19
20	Dues, Fees, Subscriptions & Promotions			16,748	16,748	194	16,942	(3,324)	13,618		20
21	Clerical & General Office Expenses	117,304	11,929	90,736	219,969	13,075	233,044	(47,581)	185,463		21
22	Employee Benefits & Payroll Taxes			532,908	532,908	11,579	544,487		544,487		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,476	4,476	401	4,877		4,877		24
25	Other Admin. Staff Transportation			1,822	1,822	100	1,922		1,922		25
26	Insurance-Prop.Liab.Malpractice			100,549	100,549		100,549		100,549		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	194,975	11,929	1,344,940	1,551,844	1,795	1,553,639	(408,787)	1,144,852		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,368,827	583,454	1,762,957	4,715,238	(144,046)	4,571,192	(416,086)	4,155,106		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 &amp; ID Number

Pine Acres Care Center

#0039289

Report Period Beginning:

07/01/04

Ending:

06/30/05

## 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	
	<b>D. Ownership</b>											
30	Depreciation			60,494	60,494		60,494	73,790	134,284			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			100,845	100,845		100,845	(3,097)	97,748			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			13,098	13,098	(13,098)						35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			174,437	174,437	(13,098)	161,339	70,693	232,032			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					151,022	151,022		151,022			39
40	Barber and Beauty Shops	25,518	554		26,072	6,122	32,194		32,194			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,153	65,153		65,153		65,153			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>	25,518	554	65,153	91,225	157,144	248,369		248,369			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,394,345	584,008	2,002,547	4,980,900		4,980,900	(345,393)	4,635,507			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 Pine Acres Care Center

# 0039289

Report Period Beginning: 07/01/04

Ending: 06/30/05

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	(7,299)	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	73,790	30		9
10	Interest and Other Investment Income	(3,097)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,581)	21		24
25	Fund Raising, Advertising and Promotional	(3,324)	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 See 5 A	(354,882)	19		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (342,393)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY							
48		49		50		51	
							52

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (342,393)</b>		<b>37</b>

\*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			X			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		151,022	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$ 151,022</b>		<b>47</b>

Pine Acres Care Center

ID# 0039289

Report Period Beginning: 07/01/04

Ending: 06/30/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Allocated G & A Not Allowed - See Schedule VIII B	\$ (312,616)	19	1
2	Cost of Proposed Sale - Cain Brothers	(50,960)	19	2
3	Cost of Proposed Sale - Interlinks	8,694	19	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
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39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(354,882)		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Pine Acres Care Center# 0039289

Report Period Beginning:

07/01/04

Ending:

06/30/05

## 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)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,299)	0	0	0	0	0	0	0	0	0	0	(7,299)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(7,299)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(7,299)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(354,882)	(3,000)	0	0	0	0	0	0	0	0	0	(357,882)	19
20	Fees, Subscriptions & Promotions	(3,324)	0	0	0	0	0	0	0	0	0	0	(3,324)	20
21	Clerical & General Office Expenses	(47,581)	0	0	0	0	0	0	0	0	0	0	(47,581)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(405,787)</b>	<b>(3,000)</b>	<b>0</b>	<b>(408,787)</b>	<b>28</b>								
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(413,086)</b>	<b>(3,000)</b>	<b>0</b>	<b>(416,086)</b>	<b>29</b>								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Pine Acres Care Center

# 0039289

Report Period Beginning:

07/01/04

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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	73,790	0	0	0	0	0	0	0	0	0	0	73,790 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(3,097)	0	0	0	0	0	0	0	0	0	0	(3,097) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	<b>TOTAL Ownership</b>	<b>70,693</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>70,693 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0 44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(342,393)</b>	<b>(3,000)</b>	<b>0</b>	<b>(345,393) 45</b>								

Facility Name & ID Number Pine Acres Care Center

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**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
<u>Bensenville Home Society</u>	<u>100</u>	<u>Anchorage of Bensenville</u>	<u>Bensenville</u>	<u>Lifelink Area</u>		<u>Independent</u>
<u>Lifelink Corporation (BHS Parent)</u>	<u>100</u>	<u>Anchorage of Beecher</u>	<u>Beecher</u>	<u>Housing</u>	<u>Various</u>	<u>Living</u>
				<u>Bridgeway of</u>		<u>Independent</u>
				<u>Bensenville</u>	<u>Bensenville</u>	<u>Living</u>
				<u>Lifelink Charities</u>	<u>Bensenville</u>	<u>Fund Raising</u>
				<u>Lifelink Services</u>	<u>Bensenville</u>	<u>Proj. Devel.</u>
				<u>See Attached</u>		

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)	
<u>1</u>	<u>V</u>	<u>19 Management Fees</u>	<u>\$ 4,321</u>	<u>Lifelink Corporation (Corporate Health Care)</u>	<u>100.00%</u>	<u>\$ 1,321</u>	<u>\$ (3,000)</u>	<u>1</u>
<u>2</u>	<u>V</u>							<u>2</u>
<u>3</u>	<u>V</u>							<u>3</u>
<u>4</u>	<u>V</u>							<u>4</u>
<u>5</u>	<u>V</u>							<u>5</u>
<u>6</u>	<u>V</u>							<u>6</u>
<u>7</u>	<u>V</u>							<u>7</u>
<u>8</u>	<u>V</u>							<u>8</u>
<u>9</u>	<u>V</u>							<u>9</u>
<u>10</u>	<u>V</u>							<u>10</u>
<u>11</u>	<u>V</u>							<u>11</u>
<u>12</u>	<u>V</u>							<u>12</u>
<u>13</u>	<u>V</u>							<u>13</u>
<u>14</u>	<u>Total</u>		<u>\$ 4,321</u>			<u>\$ 1,321</u>	<u>\$ * (3,000)</u>	<u>14</u>

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

Facility Name &amp; ID Number

Pine Acres Care Center

# 0039289

Report Period Beginning:

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## 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	<b>NO COMPENSATION IS PAID TO ANY OWNERS, RELATIVES OR BOARD MEMBERS</b>								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								<b>TOTAL</b>	\$	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 Pine Acres Care Center

# 0039289 Report Period Beginning: 07/01/04

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VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization LIFELINK CORPORATION  
 Street Address 331 S. YORK ROAD  
 City / State / Zip Code BENSENVILLE, IL. 60106  
 Phone Number ( 630) 521-8034  
 Fax Number ( 630) 521-8067

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	ADMINISTRATION	DIRECT PROG. COST	66,207,782	12	\$ 1,182,362	\$ 4,980,900	\$ 88,951	1
2	19	PROFESSIONAL SERVICES	DIRECT PROG. COST	66,207,782	12	243,935	4,980,900	18,352	2
3	20	FEES, SUBSCRIPTIONS, PROM	DIRECT PROG. COST	66,207,782	12	2,242	4,980,900	169	3
4	21	GEN. OFFICE EXPENSE	DIRECT PROG. COST	66,207,782	12	61,993	4,980,900	4,664	4
5	22	EMP. TAXES & BENEFITS	DIRECT PROG. COST	66,207,782	12	235,289	4,980,900	17,701	5
6	24	TRAVEL & SEMINARS	DIRECT PROG. COST	66,207,782	12	5,326	4,980,900	401	6
7	25	OTHER STAFF TRANS.	DIRECT PROG. COST	66,207,782	12	1,332	4,980,900	100	7
8	35	RENTAL EQUIPMENT	DIRECT PROG. COST	66,207,782	12	1,514	4,980,900	114	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					\$ 1,733,993	\$ 1,182,362	\$ 130,452	25

Facility Name & ID Number Pine Acres Care Center

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**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		7	8	9	10					
		Related**					Monthly Payment Required	Date of Note					Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
<b>A. Directly Facility Related</b>																	
<b>Long-Term</b>																	
1			X	REFINANCE MORTGAGE	***	***	\$ ***	\$ ***	***	***	\$ 100,845	1					
2				AND CAPITAL PROJECTS								2					
3												3					
4												4					
5												5					
<b>Working Capital</b>																	
6												6					
7												7					
8												8					
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 100,845	9					
<b>B. Non-Facility Related*</b>																	
10												10					
11												11					
12												12					
13												13					
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$	14					
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 100,845	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # \_\_\_\_\_

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

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



**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 Pine Acres Care Center COUNTY De Kalb

FACILITY IDPH LICENSE NUMBER 0039289

CONTACT PERSON REGARDING THIS REPORT Donald Primdahl

TELEPHONE 630-521-8034 FAX #: 630-521-8067

**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</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-27-279-003</u>	<u>Nusing Home</u>	<u>\$ 0</u>	<u>\$ 0</u>
2. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
3. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
4. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
5. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
6. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
7. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
8. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
9. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
10. _____	_____	<u>\$ _____</u>	<u>\$ _____</u>
<b>TOTALS</b>		<u>\$ _____</u>	<u>\$ _____</u>

**B. Real Estate Tax Cost Allocations**

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

If YES, attach an explanation & 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 Pine Acres Care Center

# 0039289 Report Period Beginning:

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06/30/05

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 37,295 B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 1

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).

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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>Long Term Care</u>	<u>126,760</u>	<u>1994</u>	<u>\$ 300,000</u>	1
2					2
3	<b>TOTALS</b>	<b>126,760</b>		<b>\$ 300,000</b>	<b>3</b>

Facility Name & ID Number Pine Acres Care Center# 0039289

Report Period Beginning:

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06/30/05**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	119		1994	1968	\$ 2,500,000	\$ 100,000	35	\$ 71,429	\$ (28,571)	\$ 809,528	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		1985 ADMIN. BLDG, RENOVATION		1985	130,557	3,264	40	3,264		95,527	9
10		1986 ADMIN. BLDG, RENOVATION		1986	10,060	252	40	252		6,921	10
11		HOT WATER HEATER		1994	3,432	29	10	29		3,432	11
12		WATER CONDITIONER		1994	6,813	56	10	56		6,813	12
13		(5) AIR TERMINAL UNITS		1994	9,375	312	10	312		9,375	13
14		TILE FLOORING FOR ROOMS		1995	9,074	756	10		(756)	9,074	14
15		(2) BOILER AIR DAMPERS		1995	28,538	1,427	20	1,427		14,983	15
16		REMODEL COMMON AREA		1995	12,822	855	8		(855)	12,822	16
17		RUBBER ROOF - KITCHEN		1995	19,134	1,436	10	1,436		19,134	17
18		1.25 HP DISPOSAL		1995	1,093		10	39	39	1,093	18
19		MASONRY REPAIR TO EXTERIOR WALLS		1996	5,600	186	30	186		1,711	19
20		(7) WALL UNITS		1996	8,500	850	10	850		7,933	20
21		RESURFACE PARKING LOT		1996	8,891	889	10	889		7,557	21
22		ROOF REPAIRS		1996	9,620	322	30	322		2,806	22
23		REMODLE ROOMS 121 AND 123		1997	9,985	332	30	332		2,829	23
24		REMODLE FRONT FOYER AND RECEPTION AREA		1997	13,985	467	30	467		3,963	24
25		REMODLE ROOMS 25,26 AND 35		1997	18,530	617	30	617		5,250	25
26		REMODLE BATH AREAS		1997	12,822	3,206	10	1,282	(1,924)	10,898	26
27		REMODLE STAFF LOUNGE		1997	18,635	621	30	621		4,658	27
28		INSTALL GARBAGE ENCLOSURE		1997	4,873	488	10	488		3,858	28
29		INSTALL DOMESTIC WATER		1998	7,800	260	30	260		1,950	29
30		REPLACE (23) VANITIES W/SINKS		1998	18,500	1,850	10	1,850		13,563	30
31		ROOF ADDITION		1999	88,173	2,940	30	2,940		17,880	31
32		NEW CARPETING		1999	18,018	1,801	10	1,801		11,111	32
33		(9) HEATING / AC WALL UNITS		1999	13,692	1,369	10	1,369		8,329	33
34		NEW CARPETING		1999	2,217	221	10	221		1,293	34
35		RENOVATE HALLWAY		1999	3,214	321	10	321		1,929	35
36		HEAT TAPE GUTTERS		1999	1,650	165	10	165		921	36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1	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 (40) HEAT VALVES FOR BOILER	2000	\$ 4,800	\$ 480	10	\$ 480		\$ 2,600	37
38 (5) HEAT VALVES FOR BOILER	2000	1,660	166	10	166		858	38
39 ROOF REPAIRS	2000	5,510	275	20	275		1,309	39
40 STORAGE SHED	2001	10,193	1,020	10	1,020		4,332	40
41 3 TON ROOF TOP SYSTEM	2001	17,237	1,723	10	1,723		7,182	41
42 SECURITY DOOR ALARM	2001	8,295	829	10	829		3,392	42
43 COURTYARD ASPHALT REPAIRS	2001	6,561	656	10	656		2,460	43
44 INSTALL (2) HOT WATER TANKS	2001	4,573	458	10	458		1,715	44
45 ROOF REPLACEMENT	2002	39,420	3,942	30	1,314	(2,628)	4,161	45
46 FLOOR REPAIR - ROOM 13	2002	2,092	209	10	209		645	46
47 GUARD RAILS	2002	1,418	141	10	141		413	47
48 CARPETING	2002	8,109	811	10	811		2,095	48
49 HALL REMODELING	2003	20,678	2,068	10	2,068		4,653	49
50 DOWN SPOUTS	2003	1,000	100	10	100		217	50
51 (2) WATER HEATERS	2003	5,071	507	10	507		803	51
52 FIRE ALARM SYSTEM	2004	6,400	1,280	5	1,280		1,493	52
53 ENTRANCE DOOR ALARM SYSTEM	2005	3,260	163	10	81	(82)	81	53
54 ROOF TOP AIR CONDITIONER	2005	13,310	111	10	111		111	54
55 OTHER ASSETS AND IMPAIRMENTS NOT ALLOWED								55
56								56
57								57
58								58
59								59
60 OTHER ASSETS & IMPAIRMENTS NOT ALLOWED			(108,577)			108,577		60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 3,155,190	\$ 31,654		\$ 105,454	\$ 73,800	\$ 1,135,661	70

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

Facility Name & ID Number Pine Acres Care Center

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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	\$ 276,852	\$ 27,315	\$ 27,305	\$ (10)	5 TO 10	\$ 171,782	71
72	Current Year Purchases	11,132	1,525	1,525		5 TO 10	1,525	72
73	Fully Depreciated Assets	504,155				5 TO 10	504,155	73
74								74
75	TOTALS	\$ 792,139	\$ 28,840	\$ 28,830	\$ (10)		\$ 677,462	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	2	
	Reference	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)	\$ 4,247,329	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 60,494	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 134,284	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 73,790	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,813,123	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 Pine Acres Care Center

# 0039289

Report Period Beginning: 07/01/04

Ending: 06/30/05

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

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

If NO, see instructions.  YES  NO

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

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 13,098 Description: SEE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

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

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2006 \$ \_\_\_\_\_

13. \_\_\_\_\_/2007 \$ \_\_\_\_\_

14. \_\_\_\_\_/2008 \$ \_\_\_\_\_

\* 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><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p><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><b>2. CLASSROOM PORTION:</b></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><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

<b>COMPLETED</b>	
1. From this facility	_____
2. From other facilities (f)	_____
<b>DROP-OUTS</b>	
1. From this facility	_____
2. From other facilities (f)	_____
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)								
			Units of Service	Cost	Units	Cost							
1	Licensed Occupational Therapist	10a	hrs	\$					\$ 23		\$ 23	1	
2	Licensed Speech and Language Development Therapist	10a	hrs				37					37	2
3	Licensed Recreational Therapist		hrs										3
4	Licensed Physical Therapist	10a	hrs				86,172		63			86,235	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): Medicare Therapy	10a					30,427					30,427	13
14	TOTAL			\$			\$ 116,636		\$ 86			\$ 116,722	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 &amp; ID Number Pine Acres Care Center

# 0039289

Report Period Beginning: 07/01/04

Ending: 06/30/05

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/05 (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 26,598	\$ 114,182	1
2	Cash-Patient Deposits		185,996	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 220,274 )	398,148	2,470,396	3
4	Supply Inventory (priced at )	22,650	49,792	4
5	Short-Term Investments		117,892	5
6	Prepaid Insurance	36,118	192,006	6
7	Other Prepaid Expenses	3,476	60,347	7
8	Accounts Receivable (owners or related parties)	1,087,712	8,108,571	8
9	Other(specify): See Attached		970,276	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,574,702	\$ 12,269,458	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		876,458	13
14	Buildings, at Historical Cost		21,948,912	14
15	Leasehold Improvements, at Historical Cost		696,172	15
16	Equipment, at Historical Cost		5,625,823	16
17	Accumulated Depreciation (book methods)		(22,213,455)	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): See Attached		5,459,629	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	\$ 12,393,539	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,574,702	\$ 24,662,997	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 98,036	\$ 1,452,587	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,551	212,129	28
29	Short-Term Notes Payable	1,819	14,149,540	29
30	Accrued Salaries Payable	115,541	882,702	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,337	20,231	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable		121,367	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Due to Affiliates</u>	2,254,981	24,653,282	36
37	<u>Deferred Revenue</u>	927	233,216	37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 2,478,192	\$ 41,725,054	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable		151,229	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Deferred Revenue</u>		116,279	43
44	<u>Other</u>		89,783	44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 357,291	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 2,478,192	\$ 42,082,345	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (903,490)	\$ (17,419,348)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,574,702	\$ 24,662,997	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(662,476)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(662,476)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	(238,079)	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <u>Change in Restricted Donations</u>	(2,935)	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(241,014)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(903,490)</b>	<b>24</b> *

\* This must agree with page 17, line 47.

Facility Name & ID Number Pine Acres Care Center

# 0039289

Report Period Beginning: 07/01/04

Ending:

06/30/05

**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

2

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,130,801	1
2	Discounts and Allowances for all Levels	(1,107,540)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 4,023,261	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	684,178	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 684,178	8
	<b>C. Other Operating Revenue</b>		
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	23,691	13
14	Non-Patient Meals	7,299	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 30,990	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	1,139	24
25	Interest and Other Investment Income***	3,253	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 4,392	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,742,821	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	916,616	31
32	Health Care	2,246,778	32
33	General Administration	1,551,844	33
	<b>B. Capital Expense</b>		
34	Ownership	174,437	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	26,072	35
36	Provider Participation Fee	65,153	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,980,900	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(238,079)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (238,079)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO 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 Pine Acres Care Center

# 0039289

Report Period Beginning:

07/01/04

Ending:

06/30/05

**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	1,677	2,080	\$ 58,283	\$ 28.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,153	12,259	270,571	22.07	3
4	Licensed Practical Nurses	18,211	19,529	417,848	21.40	4
5	CNAs & Orderlies	61,399	67,606	814,994	12.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,975	3,250	52,439	16.14	9
10	Activity Assistants	1,256	1,366	18,596	13.61	10
11	Social Service Workers	4,978	5,298	73,138	13.80	11
12	Dietician					12
13	Food Service Supervisor	2,046	2,163	38,776	17.93	13
14	Head Cook					14
15	Cook Helpers/Assistants	23,743	25,662	224,139	8.73	15
16	Dishwashers					16
17	Maintenance Workers	3,224	3,637	43,921	12.08	17
18	Housekeepers	13,610	15,146	131,026	8.65	18
19	Laundry					19
20	Administrator	1,858	2,080	77,671	37.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,859	2,080	34,936	16.80	23
24	Clerical	5,857	6,544	82,368	12.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,993	2,211	30,121	13.62	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beautician</u>	1,592	1,689	25,518	15.11	33
34	TOTAL (lines 1 - 33)	157,431	172,600	\$ 2,394,345 *	\$ 13.87	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	185	\$ 5,184	1-3	35
36	Medical Director		9,800	9-3	36
37	Medical Records Consultant	13	600	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	28	1,400	10a-3	40
41	Occupational Therapy Consultant	3	129	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	19	1,024	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	248	\$ 18,137		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	467	\$ 18,968	10-3	50
51	Licensed Practical Nurses	872	33,710	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,339	\$ 52,678		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Dalena Kemna-Kahn	Administrator		\$ 77,671	Workers' Compensation Insurance	\$ 69,109	IDPH License Fee	\$	
				Unemployment Compensation Insurance	15,027	Advertising: Employee Recruitment	1,369	
				FICA Taxes	174,722	Health Care Worker Background Check	840	
				Employee Health Insurance	246,582	(Indicate # of checks performed 120)		
				Employee Meals		Subscriptions/Reference Publications	10,669	
				Illinois Municipal Retirement Fund (IMRF)*		Dues	546	
				Life Insurance/Disability	10,449	Public Relations	3,324	
				Pension(TSA)	2,955	Allocation Schedule VII - B	25	
				Employee Relations/Etc.	6,946	Allocation Schedule VIII - B	169	
				Staff Medical Exams	7,118			
						Less: Public Relations Expense	(3,324)	
				Allocation Schedule VIII - B	17,701	Non-allowable advertising	( )	
				Reclass Barber Shop	(6,122)	Yellow page advertising	( )	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 544,487	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,618	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
\$ 77,671								
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
NONE			\$	NONE			Out-of-State Travel	\$
							In-State Travel	
							Seminar Expense	4,476
							Allocation Schedule VIII - B	401
							Entertainment Expense	( )
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 4,877
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)								
\$								
C. Professional Services								
Vendor/Payee	Type	Amount						
Lifelink Corporation	Mgmt. Fee	\$ 4,321						
Lifelink Corporation	Data Processing	21,806						
Lifelink Corp. & BHS Corp.	Allocated M & G	443,012						
Reingruber & Company	Medicare Consultant	4,560						
Shesky & Froelich	Legal	44,673						
Rever Health Care	A/R Consultant	14,768						
Amex	Billing Review	4,907						
Cain Brothers	Appraisal	50,960						
Interlinks	Sale Web Site	8,694						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL				
\$ 597,701				\$				

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Pine Acres Care Center

# 0039289

Report Period Beginning:

07/01/04

Ending:

06/30/05

**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?  
If YES, give association name and amount. NO
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (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?  
What was the average life used for new equipment added during this period? YES  
5-10 YRS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 28,198 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (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. \$ 65,153  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? NO Indicate the amount. \$ 0
- (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? NONE  
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: KPMG 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. AUDIT HAS NOT BEEN ISSUED
- (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.

**BENSENVILLE HOME SOCIETY**

**REPORTING PERIOD 07/01/04 - 06/30/05**

IX INTEREST EXPENSE

FACILITY NUMBER NAME

0014258 ANCHORAGE OF BENSENVILLE  
0033803 ANCHORAGE OF BEECHER  
0039289 PINE ACRES CARE CENTER

THE BENSENVILLE HOME SOCIETY (BHS) IN CONJUNCTION WITH ITS AFFILIATED CORPORATIONS, LIFELINK AND BRIDGEWAY OF BENSENVILLE, HAVE ISSUED 1989A, 1995A, AND 1998 BONDS THRU THE ILLINOIS HEALTH FACILITY AUTHORITY ON VARIOUS DATES. SEE COPY OF OFFICIAL STATEMENTS ATTACHED. THE 1989B AND 1995B BONDS WERE RETIRED WITH THE ISSUANCE OF THE 1998 BONDS.

INTEREST PAID AND ACCRUED

1989A SERIES	62,721
1995A SERIES	195,179
1998 SERIES	970,017

LETTER OF CREDIT AND OTHER FEES

1989A SERIES	57,430
1995A SERIES	144,776
1998 SERIES	4,000
TOTAL	<u>1,434,123</u>

INTEREST HAS BEEN ALLOCATED BASED ON THE USE OF THE BOND PROCEEDS.

ANCHORAGE OF BENSENVILLE	34.2% OF 1989 BONDS	41,092
	13.2% OF 1995 BONDS	43,924
	8.8% OF 1998 BONDS	85,817
	TOTAL	<u>170,833</u>
ANCHORAGE OF BEECHER	44.5% OF 1989 BONDS	53,477
	11.5% OF 1998 BONDS	111,659
	TOTAL	<u>165,136</u>
PINE ACRES CARE CENTER	30.3% OF 1995 BONDS	100,846
OTHER*		997,308
TOTAL		<u>1,434,123</u>

\* CORPORATE AND PARENT CORPORATE OFFICES AND NON-CARE RELATED.

LIFELINK CORPORATION  
BENSENVILLE HOME SOCIETY

ANCHORAGE OF BENSENVILLE	#	0014258
ANCHORAGE OF BEECHER	#	0033803
PINE ACRES CARE CENTER	#	0039289

SCHEDULE VII-A

ATTACHED ARE LISTS OF THE BOARD OF DIRECTORS FOR LIFELINK CORPORATION AND BENSENVILLE HOME SOCIETY.

NONE OF THESE DIRECTORS PROVIDE ANY SERVICES TO EITHER CORPORATION NOR DO THEY HAVE ANY OWNERSHIP IN ANY ENTITY THAT DOES BUSINESS WITH EITHER CORPORATION.

SCHEDULE VII-A3

<u>NAME</u>	<u>CITY</u>	<u>TYPE OF BUSINESS</u>
Hoyleton Youth and Family Services	Hoyleton	Social Services
Hoyleton Children's Home Foundation	Hoyleton	Fund Raising

BENSENVILLE HOME SOCIETY  
 SCHEDULE VII-B  
 6/30/2005

RECAP

VICE PRESIDENT OF HEALTH CARE (020-050)

<u>LINE #</u>	<u>DESCRIPTION</u>	<u>TOTAL</u>	<u>DIS-ALLOWED</u>	<u>ALLOWED</u>	<u>ANCHORAGE OF BENSENVILLE</u>	<u>ANCHORAGE OF BEECHER</u>	<u>PINE ACRES CARE CENTER</u>
2	FOOD PURCHASES		-	-	-	-	-
11	ACTIVITIES	-	-	-	-	-	-
17	ADMINISTRATIVE		-	-	-	-	-
19	PROFESSIONAL SERVICES	3,050		3,050	1,220	915	915
20	FEES, SUBSCRIPTIONS, PROM.	10,084	10,000	84	34	25	25
21	GENERAL OFFICE EXPENSE	1,268	-	1,268	507	380	380
22	EMPLOYMENT BENEFITS & TX.			-	-	-	-
24	TRAVEL AND SEMINARS		-	-	-	-	-
25	OTHER STAFF TRANSPORT.		-	-	-	-	-
34	RENT-FACILITIES & GROUND			-	-	-	-
35	RENTAL EQUIPMENT	-	-	-	-	-	-
	TOTAL	<u>14,402</u>	<u>10,000</u>	<u>4,402</u>	<u>1,761</u>	<u>1,321</u>	<u>1,321</u>
	ALLOCATION %				40.0%	30.0%	30.0%



**BENSENVILLE HOME SOCIETY**

**REPORTING PERIOD 07/01/04 - 06/30/05**

FACILITY NUMBER NAME

0014258	ANCHORAGE OF BENSENVILLE
0033803	ANCHORAGE OF BEECHER
0039289	PINE ACRES CARE CENTER

SCHEDULE XV BALANCE SHEET (AFTER CONSOLIDATION)

LINE 9 - OTHER

GRANTS RECEIVABLE	63,777
CONTRIBUTIONS RECEIVABLE	333,922
ASSETS HELD BY TRUSTEE	572,577
	<u>970,276</u>

LINE 23 - OTHER

BENEFICIAL INTEREST IN PERPETUAL TRUST	4,498,250
STUDENT LOANS RECEIVABLE	43,689
CASH RESTRICTED FOR STUDENT LOANS	29,789
DEFERRED COSTS AND OTHER INTANGIBLES, NET	658,203
OTHER ASSETS, NET	227,514
DUE FROM AFFILIATED CORPORATIONS	2,184
	<u>5,459,629</u>

**BENSENVILLE HOME SOCIETY**

**REPORTING PERIOD 07/01/04 - 06/30/05**

FACILITY NUMBER NAME

0039289 PINE ACRES CARE CENTER

SCHEDULE XVII - LINE 41

	(1)	(2)	BHS RELATED
	BENSENVILLE HOME <u>SOCIETY</u>	<u>FACILITY</u>	<u>(1) - (2)</u>
<u>PINE ACRES CARE CENTER</u>			
REVENUES	34,618,346	4,742,821	29,875,525
EXPENSES	35,587,146	4,980,900	30,606,246
NET INCOME (LOSS) FROM OPERATIONS	<u>(968,800)</u>	<u>(238,079)</u>	<u>(730,721)</u>

**DESCRIPTION OF LINE 24, SCHEDULE V:**

NAME	JOB TITLE	DATE	LOCATION	SEM. TITLE	SPONSOR	COST
SUE HORNER	DON	10/4/2005	GALENA	2004 NURSING LEADERSHIP CONF.	LSN	\$ 525.00
KAREN DENEKE	BILLING SUPERVISOR	12/9/2004	DAVENPORT	OSHA COMPLIANCE	CROSS COUNTRY UNIVERSITY	\$ 272.00
LAURA HARRISON DARLYN LAIRD	RN RN	12/9/2004	ROLLING MEADOWS	MDS ACCURACY	NATIONAL INST. FOR HHS	\$ 278.00
TINA VAVRA	DIR. OF DEMENTIA	1/18-1/19/05	NORTH RIVERSIDE	DEMENTIA	LSN	\$ 345.00
CHRISTI JACOBSSGAARD	DIR. OF ACTIVITIES	3/5/2005	RIVER GROVE	ACTIVITY DIR. ORIENTATION COURSE	TRITON COLLEGE	\$ 588.00
DALENA KEMNA-KAHN TINA VAVRA HOLLY RISCHE	ADMINISTRATOR DIR. OF DEMENTIA FOOD SERV. DIR.	4/20-4/22/05	CHICAGO	SPRING CONF.	LSN	\$ 984.70
ALL OTHER SEMINARS LESS THAN \$250.00:						\$1,483.00
ALLOCATED COSTS - SCHEDULE VII B:						\$ -
ALLOCATED COSTS - SCHEDULE VIII B:						\$ 401.00
SUB-TOTAL						<u>\$4,876.70</u>
OUT OF STATE SEMINARS/CONFERENCES						\$ -
<b>TOTAL</b>						<u><u>\$4,876.70</u></u>

BENSENVILLE HOME SOCIETY

SCHEDULE XI - LINES 9 & 10

1985 / 1986 ALLOCATION OF RENOVATION COSTS FOR THE CFS BUILDING

CONSTRUCTION COSTS:	<u>1985</u> 1,735,410	<u>1986</u> 133,721	
CURRENT DEPRECIATION:	43,385	3,343	
FACILITY FY 2002:	<u>BENSENVILLE</u>	<u>BEECHER</u>	<u>PINE ACRES</u>
FACILITY OPERATING EXP. (A)	10,627,094	5,103,310	4,980,900
TOTAL OPERATING EXP. (B)	66,207,782	66,207,782	66,207,782
(A) / (B)	16.05%	7.71%	7.52%
1985 COST PERCENTAGE	278,553	133,766	130,557
1985 DEPRECIATION PERCENT.	6,964	3,344	3,264
1986 COST PERCENTAGE	21,464	10,307	10,060
1986 DEPRECIATION PERCENT.	537	258	252

BENSENVILLE HOME SOCIETY  
INDIRECT COSTS  
SCHEDULE VIII-B  
6/30/2006

RECAP

LINE #	DESCRIPTION	0014258	0033803	0039289
		ANCHORAGE OF BENSENVILLE	ANCHORAGE BEECHER	PINE ACRES CARE CENTER
2	FOOD PURCHASES	-	-	-
17	ADMINISTRATIVE	189,769	91,160	88,914
19	PROFESSIONAL SERVICES	39,152	18,807	18,344
20	FEES, SUBSCRIPTIONS, PROM.	360	173	169
21	GENERAL OFFICE EXPENSE	9,950	4,780	4,662
22	EMPLOYMENT BENEFITS & TX.	37,764	18,141	17,694
24	TRAVEL AND SEMINARS	855	411	401
25	OTHER STAFF TRANSPORT.	214	103	100
26	INSURANCE	-	-	-
34	RENT-FACILITIES & GROUND	-	-	-
35	RENTAL EQUIPMENT	243	117	114
TOTAL		278,306	133,691	130,396
ALLOCATION		16.05%	7.71%	7.52%

LINE #	DESCRIPTION	LIFELINK ADMINISTRATION (010)			LIFELINK BOARD & CORPORATE (020)		
		TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	2,251	2,251	-	-	-	-
17	ADMINISTRATIVE	613,160	291,000	322,160	-	-	-
19	PROFESSIONAL SERVICES	3,570	3,525	45	4,700	-	4,700
20	FEES, SUBSCRIPTIONS, PROM.	621	230	391	-	-	-
21	GENERAL OFFICE EXPENSE	17,709	-	17,709	47	-	47
22	EMPLOYMENT BENEFITS & TX.	89,495	42,473	47,022	-	-	-
24	TRAVEL AND SEMINARS	12,739	7,413	5,326	-	-	-
25	OTHER STAFF TRANSPORT.	1,009	-	1,009	-	-	-
26	INSURANCE	-	-	-	4,092	4,092	-
34	RENT-FACILITIES & GROUND	36,053	36,053	-	-	-	-
35	RENTAL EQUIPMENT	1,043	-	1,043	-	-	-
TOTAL		777,650	382,945	394,705	8,839	4,092	4,747

LINE #	DESCRIPTION	LIFELINK BUSINESS OFFICE (030)			LIFELINK SUPPORT SERVICES (080)		
		TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	128	128	-	-	-	-
17	ADMINISTRATIVE	598,987	48,138	550,849	159,820	32,503	127,317
19	PROFESSIONAL SERVICES	1,525,868	1,388,144	137,724	229	229	-
20	FEES, SUBSCRIPTIONS, PROM.	1,587	550	1,037	84	-	84
21	GENERAL OFFICE EXPENSE	22,595	-	22,595	918	-	918
22	EMPLOYMENT BENEFITS & TX.	127,118	10,216	116,902	27,857	5,665	22,192
24	TRAVEL AND SEMINARS	1,674	1,674	-	-	-	-
25	OTHER STAFF TRANSPORT.	323	-	323	-	-	-
26	INSURANCE	-	-	-	-	-	-
34	RENT-FACILITIES & GROUND	54,672	54,672	-	4,416	4,416	-
35	RENTAL EQUIPMENT	402	-	402	-	-	-
TOTAL		2,333,354	1,503,522	829,832	193,324	42,813	150,511

LINE #	DESCRIPTION	LIFELINK MATERIALS HANDLING (110)			LIFELINK HUMAN RESOURCES (120)		
		TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	-	-	-	17	17	-
17	ADMINISTRATIVE	66,183	-	66,183	115,853	-	115,853
19	PROFESSIONAL SERVICES	5,736	-	5,736	21,150	-	21,150
20	FEES, SUBSCRIPTIONS, PROM.	152	68	84	646	-	646
21	GENERAL OFFICE EXPENSE	1,327	-	1,327	8,327	-	8,327
22	EMPLOYMENT BENEFITS & TX.	23,983	-	23,983	25,190	-	25,190
24	TRAVEL AND SEMINARS	-	-	-	-	-	-
25	OTHER STAFF TRANSPORT.	-	-	-	-	-	-
26	INSURANCE	-	-	-	-	-	-
34	RENT-FACILITIES & GROUND	804	804	-	22,176	22,176	-
35	RENTAL EQUIPMENT	69	-	69	-	-	-
TOTAL		98,254	872	97,382	193,359	22,193	171,166

LINE #	DESCRIPTION	BHS G&A BOARD & CORPORATE (010-020)			GRAND TOTAL		
		TOTAL	DIS-ALLOWED	ALLOWED	TOTAL	DIS-ALLOWED	ALLOWED
2	FOOD PURCHASES	-	-	-	2,396	2,396	-
17	ADMINISTRATIVE	-	-	-	1,554,003	371,641	1,182,362
19	PROFESSIONAL SERVICES	74,580	-	74,580	1,635,833	1,391,898	243,935
20	FEES, SUBSCRIPTIONS, PROM.	-	-	-	3,090	848	2,242
21	GENERAL OFFICE EXPENSE	11,070	-	11,070	61,993	-	61,993
22	EMPLOYMENT BENEFITS & TX.	-	-	-	293,643	58,354	235,289
24	TRAVEL AND SEMINARS	-	-	-	14,413	9,087	5,326
25	OTHER STAFF TRANSPORT.	-	-	-	1,332	-	1,332
26	INSURANCE	1,828	1,828	-	5,920	5,920	-
34	RENT-FACILITIES & GROUND	-	-	-	118,121	118,121	-
35	RENTAL EQUIPMENT	-	-	-	1,514	-	1,514
TOTAL		87,478	1,828	85,650	3,692,258	1,958,265	1,733,993

FACILITY ID#: 0039289

FACILITY NAME: PINE ACRES CARE CENTER  
A FACILITY OF THE BENSVILLE HOME SOCIETY

REPORT PERIOD: 07/01/04 - 06/30/05

SCHEDULE V

RECLASSIFICATIONS AND ADJUSTMENTS:

1. LINE 1 DIETARY	2,647	
LINE 6 MAINTENANCE	67	
LINE 10 NURSING & RECORD KEEPING	2,222	
LINE 11 ACTIVITIES	245	
LINE 21 CLERICAL & GENERAL OFFICE	8,031	
LINE 35 RENT - EQUIPMENT		13,212

TO RECLASSIFY RENTAL EQUIPMENT TO PROPER ACCOUNTS PER SCHEDULE XII B #16.

2. LINE 20 FEES, SUBSCRIPTIONS, PROM.	25	
LINE 21 CLERICAL & GENERAL OFFICE	380	
LINE 19 PROFESSIONAL SERVICES		405

TO RECLASSIFY MANAGEMENT FEES FROM PROFESSIONAL SERVICES TO PROPER ACCOUNTS.

3. LINE 40 BARBER & BEAUTY SHOP	6,122	
LINE 22 EMPLOYMENT BENEFITS & TAXES		6,122

TO RECLASSIFY COST RELATED TO OPERATION OF BEAUTY SHOP.

4. LINE 39 ANCILLARY SERVICE CENTER	151,022	
LINE 10 NURSING & RECORD KEEPING		151,022

TO RECLASSIFY PRIVATE PAY DRUGS TO SECTION D

5. LINE 17 ADMINISTRATIVE	88,951	
LINE 20 FEES, SUBSCRIPTIONS, PROM.	169	
LINE 21 CLERICAL & GENERAL OFFICE	4,664	
LINE 22 EMPLOYMENT BENEFITS & TAXES	17,701	
LINE 24 TRAVEL & SEMINARS	401	
LINE 25 OTHER STAFF TRANSPORTATION	100	
LINE 35 RENT- EQUIPEMENT AND VEHICLES	114	
LINE 19 PROFESSIONAL SERVICES		112,100

TO RECLASSIFY ALLOCATED MANAGEMENT AND GENERAL COSTS FROM PROFESSIONAL SERVICES TO PROPER ACCOUNTS.

RECAP ABOVE ENTRIES

LINE 1 DIETARY	2,647	
LINE 6 MAINTENANCE	67	
LINE 10 NURSING & RECORD KEEPING		148,800
LINE 11 ACTIVITIES	245	
LINE 17 ADMINISTRATIVE	88,951	
LINE 19 PROFESSIONAL SERVICES		112,505
LINE 20 FEES, SUBSCRIPTIONS, PROM.	194	
LINE 21 CLERICAL & GENERAL OFFICE	13,075	
LINE 22 EMPLOYMENT BENEFITS & TAXES	11,579	
LINE 24 TRAVEL & SEMINARS	401	
LINE 25 OTHER STAFF TRANSPORTATION	100	
LINE 35 RENT - EQUIPMENT		13,098
LINE 39 ANCILLARY SERVICE CENTER	151,022	
LINE 40 BARBER & BEAUTY SHOP	6,122	
LINE 41 GIFT & COFFEE SHOP		