

		FOR OFF 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.

I. IDPH Facility ID Number: 0043430

Facility Name: Provena Pine View Care Center

Address: 611 Allen Lane St Charles 60174
 Number City Zip Code

County: Kane

Telephone Number: (630) 377-2211 **Fax #** (630) 377-4352

IDPA ID Number: 371127787007

Date of Initial License for Current Owners: 03/01/98

Type of Ownership:

<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
IRS Exemption Code <u>501 C3</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 _____	

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) <u>Michael R. Gordon</u>	
	(Title) <u>VP of Finance, CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) (_____) _____ Fax # (_____) _____	

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
 201 S. Grand Avenue East
 Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Provena Pine View Care Center

0043430 Report Period Beginning: 01/01/05 Ending: 12/31/05

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 07/01/05

	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	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	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	<u>120</u>	TOTALS	<u>120</u>	<u>43,800</u>	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	<u>16,623</u>	<u>14,096</u>	<u>7,091</u>	<u>37,810</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,623</u>	<u>14,096</u>	<u>7,091</u>	<u>37,810</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.32%

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

N/A - 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 3/1/1998

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

YES Date 3/1/1998 NO

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

YES NO If YES, enter number of beds certified 120 and days of care provided 7,091

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/05 Fiscal Year: 12/31/05

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

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	
	A. General Services											
1	Dietary	278,757	44,212	22,821	345,790		345,790		345,790			1
2	Food Purchase		182,257		182,257		182,257	2,557	184,814			2
3	Housekeeping	105,612	18,588		124,200		124,200		124,200			3
4	Laundry	16,954	5,406	87,516	109,876		109,876		109,876			4
5	Heat and Other Utilities			156,207	156,207		156,207	1,375	157,582			5
6	Maintenance	65,399	8,819	52,203	126,421		126,421	40,858	167,279			6
7	Other (specify):* Pastoral Care	22,551	33	5,820	28,404		28,404	(5,530)	22,874			7
8	TOTAL General Services	489,273	259,315	324,567	1,073,155		1,073,155	39,260	1,112,415			8
	B. Health Care and Programs											
9	Medical Director			31,246	31,246		31,246		31,246			9
10	Nursing and Medical Records	2,428,808	187,168	193,281	2,809,257		2,809,257		2,809,257			10
10a	Therapy			226,274	226,274		226,274		226,274			10a
11	Activities	103,901	834	4,861	109,596		109,596	1,508	111,104			11
12	Social Services	41,336	20	660	42,016		42,016		42,016			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,574,045	188,022	456,322	3,218,389		3,218,389	1,508	3,219,897			16
	C. General Administration											
17	Administrative	270,465	22,487	636,000	928,952		928,952	(301,171)	627,781			17
18	Directors Fees											18
19	Professional Services			35,638	35,638		35,638	230,010	265,648			19
20	Dues, Fees, Subscriptions & Promotions			44,721	44,721		44,721	(14,048)	30,673			20
21	Clerical & General Office Expenses			41,169	41,169		41,169	(2,910)	38,259			21
22	Employee Benefits & Payroll Taxes			630,112	630,112		630,112	111,729	741,841			22
23	Inservice Training & Education			6,630	6,630		6,630	4,616	11,246			23
24	Travel and Seminar			9,363	9,363		9,363	5,155	14,518			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			96,065	96,065		96,065	5,538	101,603			26
27	Other (specify):* Bad Debt			53,328	53,328		53,328	(53,328)				27
28	TOTAL General Administration	270,465	22,487	1,553,026	1,845,978		1,845,978	(14,409)	1,831,569			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,333,783	469,824	2,333,915	6,137,522		6,137,522	26,359	6,163,881			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 Provena Pine View Care Center #0043430 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	
	D. Ownership											
30	Depreciation			121,965	121,965	121,965	77,959	199,924				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						159,576	159,576				32
33	Real Estate Taxes			88,760	88,760	88,760		88,760				33
34	Rent-Facility & Grounds			480,000	480,000	480,000	13,829	493,829				34
35	Rent-Equipment & Vehicles			7,353	7,353	7,353	733	8,086				35
36	Other (specify):*											36
37	TOTAL Ownership			698,078	698,078	698,078	252,097	950,175				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			392,021	392,021	392,021		392,021				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880	65,880		65,880				42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			457,901	457,901	457,901		457,901				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,333,783	469,824	3,489,894	7,293,501	7,293,501	278,456	7,571,957				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 Provena Pine View Care Center

0043430

Report Period Beginning: 01/01/05

Ending: 12/31/05

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	81	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	6,834	30		9
10	Interest and Other Investment Income	(594)	32		10
11	Discounts, Allowances, Rebates & Refunds	(13,838)	21		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	(53,328)	27		24
25	Fund Raising, Advertising and Promotional	(22,286)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (83,131)		\$	30

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)	367,117		34
35	Other- Attach Schedule	(5,530)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 361,587		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 278,456		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		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Provena Pine View Care Center

ID# 0043430

Report Period Beginning: 01/01/05

Ending: 12/31/05

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Development Misc	\$ (5,530)	7
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	(5,530)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/05

Ending:

12/31/05

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)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	81	2,476	0	0	0	0	0	0	0	0	0	2,557	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	1,375	0	0	0	0	0	0	0	0	0	1,375	5
6	Maintenance	0	483	40,375	0	0	0	0	0	0	0	0	40,858	6
7	Other (specify):*	(5,530)	0	0	0	0	0	0	0	0	0	0	(5,530)	7
8	TOTAL General Services	(5,449)	4,334	40,375	0	39,260	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,508	0	0	0	0	0	0	0	0	0	1,508	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	1,508	0	0	0	0	0	0	0	0	0	1,508	16
	C. General Administration													
17	Administrative	0	(277,642)	(23,529)	0	0	0	0	0	0	0	0	(301,171)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	27,650	202,360	0	0	0	0	0	0	0	0	230,010	19
20	Fees, Subscriptions & Promotions	(22,286)	8,238	0	0	0	0	0	0	0	0	0	(14,048)	20
21	Clerical & General Office Expenses	(13,838)	10,928	0	0	0	0	0	0	0	0	0	(2,910)	21
22	Employee Benefits & Payroll Taxes	0	44,298	67,431	0	0	0	0	0	0	0	0	111,729	22
23	Inservice Training & Education	0	4,616	0	0	0	0	0	0	0	0	0	4,616	23
24	Travel and Seminar	0	5,155	0	0	0	0	0	0	0	0	0	5,155	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	5,538	0	0	0	0	0	0	0	0	0	5,538	26
27	Other (specify):*	(53,328)	0	0	0	0	0	0	0	0	0	0	(53,328)	27
28	TOTAL General Administration	(89,452)	(171,219)	246,262	0	(14,409)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(94,901)	(165,377)	286,637	0	26,359	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/05 Ending:

12/31/05

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	6,834	0	71,125	0	0	0	0	0	0	0	0	77,959	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(594)	0	160,170	0	0	0	0	0	0	0	0	159,576	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	13,829	0	0	0	0	0	0	0	0	13,829	34
35	Rent-Equipment & Vehicles	0	0	733	0	0	0	0	0	0	0	0	733	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	6,240	0	245,857	0	252,097	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(88,661)	(165,377)	532,494	0	278,456	45							

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/05

Ending:

12/31/05

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
		See Attached		See Attached		

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	2 Food	\$	Provena Senior Services	100.00%	\$ 2,476	\$ 2,476 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,375	1,375 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	483	483 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	1,508	1,508 4
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	12,917	12,917 5
6	V	17 Administrative Salaries	451,200	Provena Senior Services	100.00%	160,641	(290,559) 6
7	V	19 Professional Services		Provena Senior Services	100.00%	27,650	27,650 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	8,238	8,238 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	10,928	10,928 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	44,298	44,298 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	4,616	4,616 11
12	V	24 Travel		Provena Senior Services	100.00%	5,155	5,155 12
13	V	26 Insurance		Provena Senior Services	100.00%	5,538	5,538 13
14	Total		\$ 451,200			\$ 285,823	\$ * (165,377) 14

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

Facility Name & ID Number Provena Pine View Care Center# 0043430Report Period Beginning: 01/01/05Ending: 12/31/05

VII. RELATED PARTIES (continued)

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)	
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 2,627	\$ 2,627	15
16	V	32 Interest		Provena Senior Services	100.00%	160,170	160,170	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	13,829	13,829	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	733	733	18
19	V	17 Admin Salaries	109,200	Provena Health Services	100.00%	71,806	(37,394)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	30,024	30,024	20
21	V	30 Depreciation		Provena Health Services	100.00%	68,498	68,498	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	202,360	202,360	22
23	V	17 Information Systems Salaries	75,600	Provena Health Services	100.00%	16,333	(59,267)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	6,829	6,829	24
25	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	7,285	7,285	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	44,815	44,815	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	18,738	18,738	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	28,317	28,317	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	11,840	11,840	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	33,090	33,090	30
31	V	39 Ancillary Services - Other	392,021	Provena Senior Services Pharmacy	100.00%	392,021		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 576,821			\$ 1,109,315	\$ * 532,494	39

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

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/05 Ending: 12/31/05

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									\$		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 Provena Pine View Care Center

0043430

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Provena Senior Services
 Street Address 19065 Hickory Creek Drive, Ste 310
 City / State / Zip Code Mokena, IL60448
 Phone Number (708)478-7900
 Fax Number (708)478-5387

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	2	Food	Management Fee Income 5,261,654	20	\$ 28,878	\$	451,200	\$ 2,476	1
2	5	Utilities	Management Fee Income 5,261,654	20	16,037		451,200	1,375	2
3	6	Maintenance - Other	Management Fee Income 5,261,654	20	5,629		451,200	483	3
4	11	Activities-Special Events	Management Fee Income 5,261,654	20	17,583		451,200	1,508	4
5	17	Admin - Misc. Other	Management Fee Income 5,261,654	20	150,633		451,200	12,917	5
6	17	Administrative Salaries	Management Fee Income 5,261,654	20	1,873,311	1,873,311	451,200	160,641	6
7	19	Professional Services	Management Fee Income 5,261,654	20	322,442		451,200	27,650	7
8	20	Dues,Subscriptions	Management Fee Income 5,261,654	20	96,069		451,200	8,238	8
9	21	Clerical Supplies	Management Fee Income 5,261,654	20	127,431		451,200	10,928	9
10	22	Employee Benefits	Management Fee Income 5,261,654	20	516,585		451,200	44,298	10
11	23	Education/Conference	Management Fee Income 5,261,654	20	53,828		451,200	4,616	11
12	24	Travel	Management Fee Income 5,261,654	20	60,116		451,200	5,155	12
13	26	Insurance	Management Fee Income 5,261,654	20	64,582		451,200	5,538	13
14	30	Depreciation	Management Fee Income 5,261,654	20	30,629		451,200	2,627	14
15	32	Interest	Management Fee Income 5,261,654	20	1,867,812		451,200	160,170	15
16	34	Rent - Facility	Management Fee Income 5,261,654	20	161,270		451,200	13,829	16
17	35	Rent - Equipment	Management Fee Income 5,261,654	20	8,543		451,200	733	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,401,378	\$ 1,873,311		\$ 463,182	25

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Provena Health Services
 Street Address 9223 West St. Francis Road
 City / State / Zip Code Frankfort, IL 60423
 Phone Number (815)469-4888
 Fax Number (815)469-4864

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	Admin Salaries	Operating Expense	1,146,264	10	\$ 753,738	\$ 753,738	109,200	\$ 71,806	1
2	22	Employee Benefits	Operating Expense	1,146,264	10	315,161		109,200	30,024	2
3	30	Depreciation	Operating Expense	1,146,264	10	719,013		109,200	68,498	3
4	19	Admin Consulting,Other	Operating Expense	1,146,264	10	2,124,158		109,200	202,360	4
5	17	Information Systems Salaries	Operating Expense	791,616	10	171,021	171,021	75,600	16,333	5
6	22	Information Systems Benefits	Operating Expense	791,616	10	71,509		75,600	6,829	6
7	6	Information Systems - Equip Main	Operating Expense	791,616	10	76,287		75,600	7,285	7
8	17	Admin Salaries	Direct Cost	1,146,264	10	470,416	470,416	109,200	44,815	8
9	22	Employee Benefits	Direct Cost	1,146,264	10	196,696		109,200	18,738	9
10	17	Information Systems Salaries	Direct Cost	791,616	10	296,512	296,512	75,600	28,317	10
11	22	Information Systems Benefits	Direct Cost	791,616	10	123,981		75,600	11,840	11
12	6	Information Systems - Equip Main	Direct Cost	791,616	10	346,486		75,600	33,090	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					\$ 5,664,978	\$ 1,691,687		\$ 539,935	25

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning: 01/01/05

Ending: 12/31/05

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 Provena Senior Services Pharmacy
 Street Address 1475 Harvard Drive
 City / State / Zip Code Kankakee, IL 60901
 Phone Number (815)928-6141
 Fax Number (815)946-3238

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	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 392,021	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 392,021	25

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										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	Provena Senior Services									159,576	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$		\$	159,576	14									
15	TOTALS (line 9+line14)					\$	\$		\$	159,576	15									

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

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

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

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 2004 report.		\$	78,858	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.)		\$	86,542	2
3. Under or (over) accrual (line 2 minus line 1).		\$	7,684	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	81,076	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.		\$	88,760	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2000	77,543	8	
	2001	75,076	9	
	2002	80,449	10	
	2003	84,737	11	
	2004	86,542	12	
				FOR OHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2004	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

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

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

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

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

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena Pine View Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0043430

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

TELEPHONE 708-478-7916 FAX #: 708-478-5387

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-27-206-005</u>	<u>00611 Allen St Charles</u>	\$ <u>86,541.85</u>	\$ <u>86,541.85</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>86,541.85</u>	\$ <u>86,541.85</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 x NO

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

C. Tax Bills

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

Facility Name & ID Number Provena Pine View Care Center

0043430 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ 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).

None

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				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/05

Ending:

12/31/05

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120				\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1999	46,268	4,298	20	4,298		30,281	9
10	Various			2000	45,044	2,693	12	2,693		16,204	10
11	Various			2001	22,263	3,599	6	3,599		16,195	11
12											12
13		DESC: REPLACE BEARING ASSEMBLY FOR DHW & C		2002	571	114	5	114		343	13
14		DESC: CARPETING IN ADMINISTRATION AND ONE		2002	1,330	266	5	266		798	14
15		DESC: REPLACE BEARING ASSEMBLY		2002	2,314	231	10	231		694	15
16		DESC: REPAIR OF SUPPLY DUCT		2002	1,700	340	5	340		1,020	16
17		DESC: REPLACE DRAIN LINES		2002	3,604	360	10	360		1,081	17
18		DESC: HVAC UNIT		2002	144,300	9,620	15	9,620		28,860	18
19		DESC: NEW CARPET FOR HALL		2002	4,005	801	5	801		2,804	19
20											20
21		DESC: EJECTOR PUMP / INSTALLATION		2003	3,805	381	10	381		951	21
22		DESC: CARPET FOR HALLWAY AND 8 RESIDENT RO		2003	8,011	1,602	5	1,602		4,005	22
23		DESC: MS9200 FIRE SYSTEM UPGRADE		2003	12,024	1,202	10	1,202		3,006	23
24		DESC: AUDIO/VISUAL DEVICES AND POWER SUPPL		2003	1,983	198	10	198		496	24
25		DESC: RENOVATION OF BATHROOMS		2003	44,093	2,940	15	2,940		7,349	25
26		DESC: SHADES AND VALANCES		2003	13,110	2,622	5	2,622		6,555	26
27		DESC: ROOF REPLACEMENT		2003	115,000	11,500	10	11,500		28,750	27
28		DESC: ROOF REPAIR		2003	24,416	2,442	10	2,442		6,104	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 Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DESC: INSTALL FIRE ALARM SYSTEM ADD ONS	2004	\$ 1,964	\$ 196	10	\$ 196	\$	\$ 295	37
38	DESC: COLLINS/AIKMAN MOISTURE BARRIER CARP	2004	455	46	10	46		68	38
39	DESC: CARPET FOR LOBBY, A-WING, & B-WING	2004	6,791	1,358	5	1,358		2,037	39
40	DESC: NEW FIRE DAMPER MOTORS	2004	4,686	469	10	469		469	40
41	DESC: FOYER W/ VIRGINIA TILE TOUCHSTONE	2004	2,390	120	20	120		120	41
42	DESC: EMERGENCY SEWER AT FACILITY	2004	2,245	449	5	449		449	42
43									43
44	DESC: FLOOR PREP FOR CARPETING IN CHAPEL	2005	404	40	5	81	40	40	44
45	DESC: PNEUMATIC OPERATOR PUSH	2005	1,496	75	10	150	75	75	45
46	DESC: SEALCOAT PARKING LOTS AND INSTALL AS	2005	17,985	899	10	1,799	899	899	46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									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)		\$ 532,259	\$ 48,861		\$ 49,876	\$ 1,014	\$ 159,948	70

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

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/05 Ending: 12/31/05

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	\$ 616,472	\$ 67,282	\$ 67,282	\$	8	\$ 400,596	71
72	Current Year Purchases	96,315	5,820	11,641	5,820	10	11,641	72
73	Fully Depreciated Assets	24,632					24,632	73
74	Home office allocation		71,125	71,125				74
75	TOTALS	\$ 737,419	\$ 144,227	\$ 150,048	\$ 5,820		\$ 436,869	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)	\$ 1,269,678	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 193,089	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 199,924	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,835	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 596,817	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: _____

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:				\$ <u>480,000</u>			3
4	Additions							4
5	Home office allocation				<u>13,829</u>			5
6								6
7	TOTAL				\$ <u>493,829</u>			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12.	<u>/2006</u>	\$ _____
13.	<u>/2007</u>	\$ _____
14.	<u>/2008</u>	\$ _____

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: \$ 95,485 Description: Nursing - #84,997.49, Dietary - \$1,688, Plant Eng - \$713.73, Admin - \$7,353, Home office\$733

(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	<u>N/A</u>		\$ _____	\$ _____	17
18					18
19					19
20					20
21	TOTAL		\$ _____	\$ _____	21

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

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

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Provena Pine View Care Center# 0043430

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	1,688	\$ 88,099	\$	1,688	\$ 88,099	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		391	20,407		391	20,407	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		2,256	117,768		2,256	117,768	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				392,021		392,021	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			\$	4,335	\$ 226,274	\$ 392,021	4,335	\$ 618,295	14

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

Facility Name & ID Number Provena Pine View Care Center# 0043430Report Period Beginning: 01/01/05

Ending:

12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(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	\$ 10,947,364	\$	1
2	Cash-Patient Deposits	102,762		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	8,022,174		3
4	Supply Inventory (priced at)	562,029		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,455		6
7	Other Prepaid Expenses	234,588		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 19,922,372	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,323,187		12
13	Land	6,872,845		13
14	Buildings, at Historical Cost	79,429,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,136,519		16
17	Accumulated Depreciation (book methods)	(44,514,067)		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): <u>Goodwill</u>	133,848		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 65,381,863	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 85,304,235	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 3,028,501	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,196,854		28
29	Short-Term Notes Payable	35,066		29
30	Accrued Salaries Payable	2,281,363		30
31	Accrued Taxes Payable (excluding real estate taxes)	52,968		31
32	Accrued Real Estate Taxes(Sch.IX-B)	222,071		32
33	Accrued Interest Payable	26,274		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Party</u>	542,408		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 8,385,505	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,329,784		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	219,687		42
Other Long-Term Liabilities(specify):				
43	<u>Conditional Asset Retirement</u>	616,044		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,165,515	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 10,551,020	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 74,753,215	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 85,304,235	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 72,625,309	1
2	Restatements (describe):		2
3	FAS47 Change in accounting principal	(271,871)	3
4	Adj. To Reconcile Consolidated Equity and Consolidated	2,554,356	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,907,794	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(184,226)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(40,261)	9
10	Stock Options Exercised		10
11	Contributions and Grants	240,328	11
12	Expenditures for Specific Purposes	(170,420)	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)	\$ (154,579)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 74,753,215	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Pine View Care Center# 0043430Report Period Beginning: 01/01/05Ending: 12/31/05**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	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,057,193	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,057,193	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	839,285	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 839,285	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	24,300	13
14	Non-Patient Meals	81	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	10,631	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	13,877	20
21	Other Medical Services		21
22	Laundry	11,750	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 60,639	23
D. Non-Operating Revenue			
24	Contributions	12,105	24
25	Interest and Other Investment Income***	594	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 12,699	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	136,230	28
28a	<u>Misc. Income</u>	3,229	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 139,459	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,109,275	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,073,155	31
32	Health Care	3,218,389	32
33	General Administration	1,845,978	33
B. Capital Expense			
34	Ownership	698,078	34
C. Ancillary Expense			
35	Special Cost Centers	392,021	35
36	Provider Participation Fee	65,880	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 7,293,501	40
41	Income before Income Taxes (line 30 minus line 40)**	(184,226)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (184,226)	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 Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/05

Ending:

12/31/05

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	1,888	2,032	\$ 70,791	\$ 34.84	1
2	Assistant Director of Nursing	1,955	2,145	57,527	26.82	2
3	Registered Nurses	23,462	25,239	659,797	26.14	3
4	Licensed Practical Nurses	19,556	20,620	500,138	24.25	4
5	CNAs & Orderlies	80,196	78,925	1,109,565	14.06	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,803	2,019	30,990	15.35	8
9	Activity Director	1,948	2,080	39,888	19.18	9
10	Activity Assistants	6,901	7,271	64,013	8.80	10
11	Social Service Workers	1,827	1,984	41,336	20.83	11
12	Dietician	1,850	2,080	43,787	21.05	12
13	Food Service Supervisor	4,356	4,588	45,834	9.99	13
14	Head Cook	22,815	23,751	189,136	7.96	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,547	3,694	65,399	17.70	17
18	Housekeepers	12,758	13,447	105,612	7.85	18
19	Laundry	1,915	2,053	16,954	8.26	19
20	Administrator	1,760	2,080	87,264	41.95	20
21	Assistant Administrator					21
22	Other Administrative	6,995	7,412	130,367	17.59	22
23	Office Manager					23
24	Clerical	6,123	6,394	52,834	8.26	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					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral Care</u>	1,641	1,753	22,551	12.86	33
34	TOTAL (lines 1 - 33)	203,296	209,567	\$ 3,333,783 *	\$ 15.91	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	377	\$ 19,607	1,3	35
36	Medical Director	\$600/mth	7,200	9,3	36
37	Medical Records Consultant	38	2,180	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	23	1,068	11,3	44
45	Social Service Consultant	12	660	12,3	45
46	Other(specify)				46
47	<u>Podiatrist</u>	<u>\$1488/mth</u>	<u>17,850</u>	<u>9,3</u>	47
48					48
49	TOTAL (lines 35 - 48)	450	\$ 48,565		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,467	\$ 69,271	10,3	50
51	Licensed Practical Nurses	43	1,656	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,510	\$ 70,927		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. 5265 - Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 120
- (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? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 35,309 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. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,880
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 81
- (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. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: 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. Not issued yet
- (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.