

		FOR BHF USE				

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

HFS 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 01/01/06 to 12/31/06 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: 01/01/06 Ending: 12/31/06

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	120	Skilled (SNF)	120	43,800	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	120	TOTALS	120	43,800	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	18,310	12,077	8,217	38,604	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,310	12,077	8,217	38,604	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.14%

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 03/1/1998

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

YES Date 03/01/1998 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 7,858

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/06 Fiscal Year: 12/31/06

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

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/06 Ending: 12/31/06

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	285,316	43,927	29,167	358,410		358,410		358,410			1
2	Food Purchase		213,662		213,662		213,662	2,872	216,534			2
3	Housekeeping	111,817	17,206	817	129,840		129,840		129,840			3
4	Laundry	17,352	2,044	82,169	101,565		101,565		101,565			4
5	Heat and Other Utilities			137,511	137,511		137,511	1,048	138,559			5
6	Maintenance	67,364	15,741	66,611	149,716		149,716	40,289	190,005			6
7	Other (specify):* Pastoral Care	29,452	913	3,998	34,363		34,363	(4,487)	29,876			7
8	TOTAL General Services	511,301	293,493	320,273	1,125,067		1,125,067	39,722	1,164,789			8
	B. Health Care and Programs											
9	Medical Director			30,900	30,900		30,900		30,900			9
10	Nursing and Medical Records	2,603,963	175,419	171,905	2,951,287		2,951,287		2,951,287			10
10a	Therapy			383,607	383,607		383,607		383,607			10a
11	Activities	103,597	666	9,507	113,770		113,770	1,208	114,978			11
12	Social Services	44,607		426	45,033		45,033		45,033			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,752,167	176,085	596,345	3,524,597		3,524,597	1,208	3,525,805			16
	C. General Administration											
17	Administrative	305,560	21,388	706,560	1,033,508		1,033,508	(361,151)	672,357			17
18	Directors Fees											18
19	Professional Services			22,784	22,784		22,784	254,822	277,606			19
20	Dues, Fees, Subscriptions & Promotions			34,175	34,175		34,175	(9,902)	24,273			20
21	Clerical & General Office Expenses			91,304	91,304		91,304	(164,712)	(73,408)			21
22	Employee Benefits & Payroll Taxes			673,994	673,994		673,994	110,810	784,804			22
23	Inservice Training & Education			12,139	12,139		12,139	3,650	15,789			23
24	Travel and Seminar			10,349	10,349		10,349	5,491	15,840			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			118,560	118,560		118,560	135	118,695			26
27	Other (specify):* Bad Debt			133,701	133,701		133,701	(133,701)				27
28	TOTAL General Administration	305,560	21,388	1,803,566	2,130,514		2,130,514	(294,558)	1,835,956			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,569,028	490,966	2,720,184	6,780,178		6,780,178	(253,628)	6,526,550			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: 01/01/06 Ending: 12/31/06

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			134,398	134,398		134,398	89,145	223,543			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							173,502	173,502			32
33	Real Estate Taxes			89,120	89,120		89,120		89,120			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	13,211	493,211			34
35	Rent-Equipment & Vehicles			8,361	8,361		8,361	1,188	9,549			35
36	Other (specify):*											36
37	TOTAL Ownership			711,879	711,879		711,879	277,046	988,925			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			451,353	451,353		451,353		451,353			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,700	65,700		65,700		65,700			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			517,053	517,053		517,053		517,053			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,569,028	490,966	3,949,116	8,009,110		8,009,110	23,418	8,032,528			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:

01/01/06

Ending:

12/31/06

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	(168)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,802	30		9
10	Interest and Other Investment Income	(195)	32		10
11	Discounts, Allowances, Rebates & Refunds	(173,497)	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	(133,701)	27		24
25	Fund Raising, Advertising and Promotional	(16,917)	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)	\$ (314,676)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	342,581		34
35	Other- Attach Schedule	(4,487)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 338,094		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 23,418		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

BHF USE ONLY						
48		49		50		51
						52

Provena Pine View Care Center

ID# 0043430

Report Period Beginning: 01/01/06

Ending: 12/31/06

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Office Supplies	\$ (544)	7	1
2	Development Misc.	(3,943)	7	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	(4,487)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/06

Ending:

12/31/06

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	(168)	3,040	0	0	0	0	0	0	0	0	0	2,872	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	1,048	0	0	0	0	0	0	0	0	0	1,048	5
6	Maintenance	0	207	40,082	0	0	0	0	0	0	0	0	40,289	6
7	Other (specify):*	(4,487)	0	0	0	0	0	0	0	0	0	0	(4,487)	7
8	TOTAL General Services	(4,655)	4,295	40,082	0	39,722	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	1,208	0	0	0	0	0	0	0	0	0	1,208	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	1,208	0	0	0	0	0	0	0	0	0	1,208	16
	C. General Administration													
17	Administrative	0	(295,346)	(65,805)	0	0	0	0	0	0	0	0	(361,151)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	28,427	226,395	0	0	0	0	0	0	0	0	254,822	19
20	Fees, Subscriptions & Promotions	(16,917)	7,015	0	0	0	0	0	0	0	0	0	(9,902)	20
21	Clerical & General Office Expenses	(173,497)	8,785	0	0	0	0	0	0	0	0	0	(164,712)	21
22	Employee Benefits & Payroll Taxes	0	45,615	65,195	0	0	0	0	0	0	0	0	110,810	22
23	Inservice Training & Education	0	3,650	0	0	0	0	0	0	0	0	0	3,650	23
24	Travel and Seminar	0	5,491	0	0	0	0	0	0	0	0	0	5,491	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	135	0	0	0	0	0	0	0	0	0	135	26
27	Other (specify):*	(133,701)	0	0	0	0	0	0	0	0	0	0	(133,701)	27
28	TOTAL General Administration	(324,115)	(196,228)	225,785	0	(294,558)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(328,770)	(190,725)	265,867	0	(253,628)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Pine View Care Center

0043430 Report Period Beginning:

01/01/06 Ending:

12/31/06

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	9,802	0	79,343	0	0	0	0	0	0	0	0	89,145	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(195)	0	173,697	0	0	0	0	0	0	0	0	173,502	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	13,211	0	0	0	0	0	0	0	0	13,211	34
35	Rent-Equipment & Vehicles	0	0	1,188	0	0	0	0	0	0	0	0	1,188	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,607	0	267,439	0	277,046	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)	(319,163)	(190,725)	533,306	0	23,418	45							

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/06

Ending:

12/31/06

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 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 3,040	\$ 3,040	1
2	V	5 Utilities		Provena Senior Services	100.00%	1,048	1,048	2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	207	207	3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	1,208	1,208	4
5	V	17 Admin - Misc. Other	473,760	Provena Senior Services	100.00%	9,889	(463,871)	5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	168,525	168,525	6
7	V	19 Professional Services		Provena Senior Services	100.00%	28,427	28,427	7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	7,015	7,015	8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	8,785	8,785	9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	45,615	45,615	10
11	V	23 Education/Conference		Provena Senior Services	100.00%	3,650	3,650	11
12	V	24 Travel		Provena Senior Services	100.00%	5,491	5,491	12
13	V	26 Insurance		Provena Senior Services	100.00%	135	135	13
14	Total		\$ 473,760			\$ 283,035	\$ * (190,725)	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: 01/01/06Ending: 12/31/06

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%	\$ 2,710	\$ 2,710	15
16	V	32 Interest		Provena Senior Services	100.00%	173,697	173,697	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	13,211	13,211	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	1,188	1,188	18
19	V	17 Admin Salaries	111,360	Provena Health Services	100.00%	70,568	(40,792)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	27,549	27,549	20
21	V	30 Depreciation		Provena Health Services	100.00%	76,633	76,633	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	226,395	226,395	22
23	V	17 Information Systems Salaries	121,440	Provena Health Services	100.00%	17,107	(104,333)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	6,679	6,679	24
25	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	11,029	11,029	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	47,435	47,435	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	18,519	18,519	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	31,885	31,885	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	12,448	12,448	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	29,053	29,053	30
31	V	39 Ancillary Services - Other	451,353	Provena Senior Services Pharmacy	100.00%	451,353		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 684,153			\$ 1,217,459	\$ * 533,306	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: 01/01/06 Ending: 12/31/06

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:

01/01/06

Ending: 12/31/06

VIII. ALLOCATION OF INDIRECT COSTS

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

Name of Related Organization 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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 5,596,693	20	\$ 35,910	\$	473,760	\$ 3,040	1
2	5	Utilities	Management Fee Income 5,596,693	20	12,383		473,760	1,048	2
3	6	Maintenance - Other	Management Fee Income 5,596,693	20	2,446		473,760	207	3
4	11	Activities-Special Events	Management Fee Income 5,596,693	20	14,275		473,760	1,208	4
5	17	Admin - Misc. Other	Management Fee Income 5,596,693	20	116,818		473,760	9,889	5
6	17	Administrative Salaries	Management Fee Income 5,596,693	20	1,990,843	1,990,843	473,760	168,525	6
7	19	Professional Services	Management Fee Income 5,596,693	20	335,820		473,760	28,427	7
8	20	Dues,Subscriptions	Management Fee Income 5,596,693	20	82,869		473,760	7,015	8
9	21	Clerical Supplies	Management Fee Income 5,596,693	20	103,786		473,760	8,785	9
10	22	Employee Benefits	Management Fee Income 5,596,693	20	538,870		473,760	45,615	10
11	23	Education/Conference	Management Fee Income 5,596,693	20	43,116		473,760	3,650	11
12	24	Travel	Management Fee Income 5,596,693	20	64,864		473,760	5,491	12
13	26	Insurance	Management Fee Income 5,596,693	20	1,591		473,760	135	13
14	30	Depreciation	Management Fee Income 5,596,693	20	32,015		473,760	2,710	14
15	32	Interest	Management Fee Income 5,596,693	20	2,051,940		473,760	173,697	15
16	34	Rent - Facility	Management Fee Income 5,596,693	20	156,067		473,760	13,211	16
17	35	Rent - Equipment	Management Fee Income 5,596,693	20	14,036		473,760	1,188	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,597,649	\$ 1,990,843		\$ 473,841	25

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/06

Ending: 12/31/06

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	1,192,116	10	\$ 755,436	\$ 755,436	111,360	\$ 70,568	1
2	22	Employee Benefits	Operating Expense	1,192,116	10	294,918		111,360	27,549	2
3	30	Depreciation	Operating Expense	1,192,116	10	820,363		111,360	76,633	3
4	19	Admin Consulting,Other	Operating Expense	1,192,116	10	2,423,574		111,360	226,395	4
5	17	Information Systems Salaries	Operating Expense	1,301,820	10	183,390	183,390	121,440	17,107	5
6	22	Information Systems Benefits	Operating Expense	1,301,820	10	71,595		121,440	6,679	6
7	6	Information Systems - Equip Main	Operating Expense	1,301,820	10	118,233		121,440	11,029	7
8	17	Admin Salaries	Direct Cost	1,192,116	10	507,799	507,799	111,360	47,435	8
9	22	Employee Benefits	Direct Cost	1,192,116	10	198,242		111,360	18,519	9
10	17	Information Systems Salaries	Direct Cost	1,301,820	10	341,798	341,798	121,440	31,885	10
11	22	Information Systems Benefits	Direct Cost	1,301,820	10	133,436		121,440	12,448	11
12	6	Information Systems - Equip Main	Direct Cost	1,301,820	10	311,444		121,440	29,053	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					\$ 6,160,228	\$ 1,788,423		\$ 575,300	25

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/06

Ending: 12/31/06

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		\$	\$		\$ 451,353	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				\$	\$		\$ 451,353	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	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	<u>Provena Senior Services</u>									173,502	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$		\$	173,502	14									
15	TOTALS (line 9+line14)					\$	\$		\$	173,502	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 2005 report.		\$	81,076	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.)		\$	83,836	2
3. Under or (over) accrual (line 2 minus line 1).		\$	2,760	3
4. Real Estate Tax accrual used for 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	86,360	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.		\$	89,120	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2001	75,076	8	
	2002	80,449	9	
	2003	84,737	10	
	2004	86,542	11	
	2005	83,836	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2005	\$	13
	14	PLUS APPEAL COST FROM LINE 5	\$	14
	15	LESS REFUND FROM LINE 6	\$	15
	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

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

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 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 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>09-27-206-005</u>	<u>00611 Allen St Charles</u>	<u>\$ 83,835.52</u>	<u>\$ 83,835.52</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ 83,835.52	\$ 83,835.52

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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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

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:

01/01/06

Ending:

12/31/06

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120				\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1999		46,268	4,298	20	4,298		34,579	9
10	Various		2000		45,044	2,383	12	2,383		18,587	10
11	Various		2001		22,263	2,521	6	2,521		18,716	11
12	Various		2002		157,826	11,733	8	11,733		47,334	12
13											13
14		DESC: EJECTOR PUMP / INSTALLATION	2003		3,805	381	10	381		1,332	14
15		DESC: CARPET FOR HALLWAY AND 8 RESIDENT R	2003		8,011	1,602	5	1,602		5,607	15
16		DESC: MS9200 FIRE SYSTEM UPGRADE	2003		12,024	1,202	10	1,202		4,208	16
17		DESC: AUDIO/VISUAL DEVICES AND POWER SUPP	2003		1,983	198	10	198		694	17
18		DESC: RENOVATION OF BATHROOMS	2003		44,093	2,940	15	2,940		10,288	18
19		DESC: SHADES AND VALANCES	2003		13,110	2,622	5	2,622		9,177	19
20		DESC: ROOF REPLACEMENT	2003		115,000	11,500	10	11,500		40,250	20
21		DESC: ROOF REPAIR	2003		24,416	2,442	10	2,442		8,546	21
22											22
23		DESC: INSTALL FIRE ALARM SYSTEM ADD ONS	2004		1,964	196	10	196		491	23
24		DESC: COLLINS/AIKMAN MOISTURE BARRIER CAR	2004		455	46	10	46		114	24
25		DESC: CARPET FOR LOBBY, A-WING, & B-WING	2004		6,791	1,358	5	1,358		3,396	25
26		DESC: NEW FIRE DAMPER MOTORS	2004		4,686	469	10	469		937	26
27		DESC: FOYER W/ VIRGINIA TILE TOUCHSTONE	2004		2,390	120	20	120		239	27
28		DESC: EMERGENCY SEWER AT FACILITY	2004		2,245	449	5	449		898	28
29											29
30		DESC: FLOOR PREP FOR CARPETING IN CHAPEL	2005		404	81	5	81		121	30
31		DESC: PNEUMATIC OPERATOR PUSH	2005		1,496	150	10	150		224	31
32		DESC: SEALCOAT PARKING LOTS AND INSTALL A	2005		17,985	1,799	10	1,799		2,698	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:

01/01/06

Ending:

12/31/06

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: FIRESTOP BASEMENT WALLS, FLOOR AND	2006	\$ 7,532	\$ 377	10	\$ 753	\$ 377	\$ 377	37
38	DESC: 10 NEW CONCRETE STEPS W/ RAILING	2006	4,850	162	15	323	162	162	38
39	DESC: 35 REPLACEMENT WINDOWS	2006	29,750	1,488	10	2,975	1,488	1,488	39
40	DESC: BACK DOOR REPLACEMENT	2006	2,262	57	20	226	170	57	40
41	DESC: 3 DOORS, HINGES AND LEVER HANDLES	2006	2,780	93	15	185	93	93	41
42									42
43									43
44									44
45									45
46									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)		\$ 579,433	\$ 50,663		\$ 52,951	\$ 2,288	\$ 210,611	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: 01/01/06 Ending: 12/31/06

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	\$ 705,684	\$ 76,041	\$ 76,041		9	\$ 456,011	71
72	Current Year Purchases	152,088	7,695	15,209	7,514	10	7,695	72
73	Fully Depreciated Assets	31,735					31,735	73
74	Home Office Allocation		79,343	79,343				74
75	TOTALS	\$ 889,507	\$ 163,078	\$ 170,592	\$ 7,514		\$ 495,441	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)	\$ 1,468,940	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 213,741	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 223,543	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,802	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 706,052	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: Klapmeir

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>13,211</u>			5
6								6
7	TOTAL				\$ <u>493,211</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>/2007</u>	\$ _____
13.	<u>/2008</u>	\$ _____
14.	<u>/2009</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: \$ 83,804 Description: Nursing \$72,800, Dietary \$1,455, Admin \$8,361, Home Office \$1,188

(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.

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:

01/01/06

Ending:

12/31/06

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	\$	2,892	\$ 150,979	\$	2,892	\$ 150,979	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,067	55,718		1,067	55,718	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		3,389	176,910		3,389	176,910	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				451,353		451,353	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			\$	7,348	\$ 383,607	\$ 451,353	7,348	\$ 834,960	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: 01/01/06

Ending:

12/31/06

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/06

(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	\$ 9,196,621	\$	1
2	Cash-Patient Deposits	104,225		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	10,284,617		3
4	Supply Inventory (priced at)	527,496		4
5	Short-Term Investments			5
6	Prepaid Insurance	17,880		6
7	Other Prepaid Expenses	180,330		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,311,169	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,785,655		12
13	Land	6,865,930		13
14	Buildings, at Historical Cost	81,049,403		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	17,957,954		16
17	Accumulated Depreciation (book methods)	(48,335,409)		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>	126,984		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,450,517	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 84,761,686	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 3,462,064	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,875,684		28
29	Short-Term Notes Payable	38,451		29
30	Accrued Salaries Payable	2,295,855		30
31	Accrued Taxes Payable (excluding real estate taxes)	68,182		31
32	Accrued Real Estate Taxes(Sch.IX-B)	676,390		32
33	Accrued Interest Payable	32,958		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to Related Party</u>	595,505		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,045,089	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,289,822		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	276,292		42
	Other Long-Term Liabilities(specify):			
43	<u>Conditional Asset Retirement</u>	647,900		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,214,014	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 11,259,103	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 73,502,583	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 84,761,686	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 74,753,215	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(3,000,000)	3
4	Adj. To reconcile consolidated equity & consolidated income	1,812,217	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,565,432	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(319,046)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	85,263	9
10	Stock Options Exercised		10
11	Contributions and Grants	381,287	11
12	Expenditures for Specific Purposes	(210,353)	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)	\$ (62,849)	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)	\$ 73,502,583	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Pine View Care Center# 0043430Report Period Beginning: 01/01/06Ending: 12/31/06**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	\$ 6,282,732	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,282,732	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,154,709	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,154,709	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	25,043	13
14	Non-Patient Meals	168	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	11,749	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	9,207	20
21	Other Medical Services		21
22	Laundry	11,925	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 58,092	23
D. Non-Operating Revenue			
24	Contributions	18,783	24
25	Interest and Other Investment Income***	195	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 18,978	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	173,497	28
28a	<u>Misc. Income</u>	2,056	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 175,553	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,690,064	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,125,067	31
32	Health Care	3,524,598	32
33	General Administration	2,130,513	33
B. Capital Expense			
34	Ownership	711,879	34
C. Ancillary Expense			
35	Special Cost Centers	451,353	35
36	Provider Participation Fee	65,700	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,009,110	40
41	Income before Income Taxes (line 30 minus line 40)**	(319,046)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (319,046)	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:

01/01/06

Ending:

12/31/06

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	1,904	2,048	\$ 78,019	\$ 38.10	1
2	Assistant Director of Nursing	1,738	1,859	54,450	29.29	2
3	Registered Nurses	29,406	31,693	904,953	28.55	3
4	Licensed Practical Nurses	13,615	14,517	353,051	24.32	4
5	CNAs & Orderlies	77,401	82,024	1,202,972	14.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	672	755	10,518	13.93	8
9	Activity Director	1,976	2,120	41,197	19.43	9
10	Activity Assistants	6,034	6,513	62,400	9.58	10
11	Social Service Workers	1,916	2,068	44,607	21.57	11
12	Dietician	1,868	2,080	43,823	21.07	12
13	Food Service Supervisor					13
14	Head Cook	4,421	4,711	46,363	9.84	14
15	Cook Helpers/Assistants	23,406	24,589	195,130	7.94	15
16	Dishwashers					16
17	Maintenance Workers	3,775	4,124	67,364	16.33	17
18	Housekeepers	12,763	13,475	111,817	8.30	18
19	Laundry	1,754	1,975	17,352	8.79	19
20	Administrator	1,840	2,080	95,365	45.85	20
21	Assistant Administrator					21
22	Other Administrative	8,677	9,376	171,651	18.31	22
23	Office Manager					23
24	Clerical	4,419	4,622	38,544	8.34	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>	1,552	1,600	29,452	18.41	33
34	TOTAL (lines 1 - 33)	199,137	212,229	\$ 3,569,028 *	\$ 16.82	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	373	\$ 22,958	1,3	35
36	Medical Director	\$600/mo	7,200	9,3	36
37	Medical Records Consultant	16	920	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	41	1,915	11,3	44
45	Social Service Consultant	12	646	12,3	45
46	Other(specify)				46
47	<u>Podiatrist</u>	\$1975/mo	23,700	9,3	47
48					48
49	TOTAL (lines 35 - 48)	442	\$ 57,339		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	674	\$ 35,416	10,3	50
51	Licensed Practical Nurses	437	18,144	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,111	\$ 53,560		53

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning: 01/01/06

Ending: 12/31/06

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	
Mary Pat Wright	Administrator	0	\$ 95,365	Workers' Compensation Insurance	\$ 69,000	IDPH License Fee	\$	
Administrative Staff	Admissions	0	41,819	Unemployment Compensation Insurance	16,177	Advertising: Employee Recruitment		
Administrative Staff	Human Resources	0	38,664	FICA Taxes	259,697	Health Care Worker Background Check		
Administrative Staff	Bookkeeper	0	26,217	Employee Health Insurance	195,049	(Indicate # of checks performed <u>40</u>)		
Administrative Staff	Receptionist	0	38,544	Employee Meals		Patient Background Checks <u>247</u>		
Administrative Staff	Comm. Resource	0	38,313	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	6,418	
Administrative Staff	Admitting Specialist	0	26,638	Life Insurance	14,006	Dues & Subscription	8,882	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	98,853	Advertising & Public Relations	18,875	
(List each licensed administrator separately.)			\$ 305,560	Employee Recognition	1,955			
B. Administrative - Other				Executive Benefits	7,442	Home Office Allocation	7,015	
Description			Amount	Employee Screenings	11,815	Less: Public Relations Expense	()	
Corp Service Fee			\$ 111,360	Home Office Allocation	110,810	Non-allowable advertising	(16,917)	
Corp Service IS Fee			121,440			Yellow page advertising	()	
Mgmt Fee			330,000	TOTAL (agree to Schedule V, line 22, col.8)			\$ 784,804	
Mgmt Fee Interest			143,760	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 706,560	Description	Line #	Amount		
(Attach a copy of any management service agreement)				N/A		\$		
C. Professional Services				G. Schedule of Travel and Seminar**				
Vendor/Payee	Type		Amount	Description			Amount	
Legal Expense	Various		\$ 2,555	Out-of-State Travel			\$	
Beautician	Various		4,862					
Survey & Analytical Tools	Various		8,604	In-State Travel			10,349	
Cleaning	Various		3,368					
Employee Screening	Various		3,395	Seminar Expense				
				Home Office Allocation			5,491	
				Entertainment Expense			()	
				(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$ 15,840	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 22,784					

* Attach copy of IMRF notifications

**See instructions.

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. \$ 45,638 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. \$ 65,700
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. \$ 168
- (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 \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.