

		FOR BHF USE					

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2007
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2007)

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 License 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 01/01/07 to 12/31/07 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: 01/01/07 Ending: 12/31/07

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	<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>18,982</u>	<u>11,945</u>	<u>6,688</u>	<u>37,615</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>18,982</u>	<u>11,945</u>	<u>6,688</u>	<u>37,615</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.88%

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 03/01/1998

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 6,688

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/07 Fiscal Year: 12/31/07

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

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/07 Ending: 12/31/07

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 BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	285,269	33,371	36,207	354,847		354,847		354,847		1
2	Food Purchase		254,038		254,038		254,038	2,880	256,918		2
3	Housekeeping	111,163	20,614		131,777		131,777		131,777		3
4	Laundry	19,054	1,955	83,582	104,591		104,591		104,591		4
5	Heat and Other Utilities			138,649	138,649		138,649	1,320	139,969		5
6	Maintenance	71,301	18,056	66,753	156,110		156,110	21,297	177,407		6
7	Other (specify):* Pastoral Care	37,305	22	6,359	43,686		43,686	5,782	49,468		7
8	TOTAL General Services	524,092	328,056	331,550	1,183,698		1,183,698	31,279	1,214,977		8
	B. Health Care and Programs										
9	Medical Director			20,425	20,425		20,425		20,425		9
10	Nursing and Medical Records	2,654,501	178,659	149,038	2,982,198		2,982,198		2,982,198		10
10a	Therapy			438,159	438,159		438,159		438,159		10a
11	Activities	101,017	1,453	4,741	107,211		107,211	412	107,623		11
12	Social Services	46,809		564	47,373		47,373		47,373		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,802,327	180,112	612,927	3,595,366		3,595,366	412	3,595,778		16
	C. General Administration										
17	Administrative	291,259	28,041	700,320	1,019,620		1,019,620	(151,578)	868,042		17
18	Directors Fees										18
19	Professional Services			30,727	30,727		30,727	138,878	169,605		19
20	Dues, Fees, Subscriptions & Promotions			22,272	22,272		22,272	(1,927)	20,345		20
21	Clerical & General Office Expenses			38,238	38,238		38,238	7,176	45,414		21
22	Employee Benefits & Payroll Taxes			797,702	797,702		797,702	84,572	882,274		22
23	Inservice Training & Education			13,560	13,560		13,560	3,424	16,984		23
24	Travel and Seminar			11,455	11,455		11,455	4,891	16,346		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			112,800	112,800		112,800	903	113,703		26
27	Other (specify):* Bad Debt			70,406	70,406		70,406	(70,406)			27
28	TOTAL General Administration	291,259	28,041	1,797,480	2,116,780		2,116,780	15,933	2,132,713		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,617,678	536,209	2,741,957	6,895,844		6,895,844	47,624	6,943,468		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: 01/01/07 Ending: 12/31/07

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			142,916	142,916		142,916	108,814	251,730			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							129,932	129,932			32
33	Real Estate Taxes			100,800	100,800		100,800		100,800			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	11,736	491,736			34
35	Rent-Equipment & Vehicles			9,021	9,021		9,021	1,597	10,618			35
36	Other (specify):*											36
37	TOTAL Ownership			732,737	732,737		732,737	252,079	984,816			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			411,135	411,135		411,135	(196,687)	214,448			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,520	65,520		65,520		65,520			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			476,655	476,655		476,655	(196,687)	279,968			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,617,678	536,209	3,951,349	8,105,236		8,105,236	103,016	8,208,252			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: 01/01/07

Ending: 12/31/07

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	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	9,181	30		9
10	Interest and Other Investment Income	(14,205)	32		10
11	Discounts, Allowances, Rebates & Refunds	(196,687)	39		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	(70,406)	27		24
25	Fund Raising, Advertising and Promotional	(8,489)	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)	\$ (280,606)		\$	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)	377,840		34
35	Other- Attach Schedule	(5,782)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 372,058		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 91,452		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					45
46	Other-Attach Schedule					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: 01/01/07

Ending: 12/31/07

Sch. V Line Reference

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Development Misc	\$ 5,782	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	5,782	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	0	2,880	0	0	0	0	0	0	0	0	0	2,880	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	1,320	0	0	0	0	0	0	0	0	0	1,320	5
6	Maintenance	0	347	20,950	0	0	0	0	0	0	0	0	21,297	6
7	Other (specify):*	5,782	0	0	0	0	0	0	0	0	0	0	5,782	7
8	TOTAL General Services	5,782	4,547	20,950	0	31,279	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	412	0	0	0	0	0	0	0	0	0	412	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	412	0	0	0	0	0	0	0	0	0	412	16
	C. General Administration													
17	Administrative	0	(282,418)	130,840	0	0	0	0	0	0	0	0	(151,578)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	47,565	91,313	0	0	0	0	0	0	0	0	138,878	19
20	Fees, Subscriptions & Promotions	(8,489)	6,562	0	0	0	0	0	0	0	0	0	(1,927)	20
21	Clerical & General Office Expenses	0	7,176	0	0	0	0	0	0	0	0	0	7,176	21
22	Employee Benefits & Payroll Taxes	0	38,199	46,373	0	0	0	0	0	0	0	0	84,572	22
23	Inservice Training & Education	0	3,424	0	0	0	0	0	0	0	0	0	3,424	23
24	Travel and Seminar	0	4,891	0	0	0	0	0	0	0	0	0	4,891	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	903	0	0	0	0	0	0	0	0	0	903	26
27	Other (specify):*	(70,406)	0	0	0	0	0	0	0	0	0	0	(70,406)	27
28	TOTAL General Administration	(78,895)	(173,698)	268,526	0	15,933	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(73,113)	(168,739)	289,476	0	47,624	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/07 Ending:

12/31/07

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	9,181	0	99,633	0	0	0	0	0	0	0	0	108,814	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(14,205)	0	144,137	0	0	0	0	0	0	0	0	129,932	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	11,736	0	0	0	0	0	0	0	0	11,736	34
35	Rent-Equipment & Vehicles	0	0	1,597	0	0	0	0	0	0	0	0	1,597	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(5,024)	0	257,103	0	252,079	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	(196,687)	0	0	0	0	0	0	0	0	0	0	(196,687)	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	(196,687)	0	0	0	0	0	0	0	0	0	0	(196,687)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(274,824)	(168,739)	546,579	0	103,016	45							

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/07

Ending:

12/31/07

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%	\$ 2,880	\$ 2,880 1
2	V	5 Utilities		Provena Senior Services	100.00%	1,320	1,320 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	347	347 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	412	412 4
5	V	17 Admin - Misc. Other	432,360	Provena Senior Services	100.00%	8,623	(423,737) 5
6	V	17 Administrative Services		Provena Senior Services	100.00%	141,319	141,319 6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	47,565	47,565 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	6,562	6,562 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	7,176	7,176 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	38,199	38,199 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	3,424	3,424 11
12	V	24 Travel		Provena Senior Services	100.00%	4,891	4,891 12
13	V	26 Insurance		Provena Senior Services	100.00%	903	903 13
14	Total		\$ 432,360			\$ 263,621	\$ * (168,739) 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: 01/01/07Ending: 12/31/07

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%	\$ 2,548	\$ 2,548	15
16	V	32 Interest		Provena Senior Services	100.00%	144,137	144,137	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	11,736	11,736	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	1,597	1,597	18
19	V	17 Admin Salaries	110,640	Provena Health Services	100.00%	88,846	(21,794)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	20,912	20,912	20
21	V	30 Depreciation		Provena Health Services	100.00%	97,085	97,085	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	91,313	91,313	22
23	V	17 Information Systems Salaries	157,320	Provena Health Services	100.00%	30,272	(127,048)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	6,942	6,942	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	201,003	201,003	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	42,285	42,285	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	9,953	9,953	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	36,394	36,394	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	8,566	8,566	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	20,950	20,950	30
31	V	39 Ancillary Services - Other	411,135	Provena Senior Services Pharmacy	100.00%	411,135		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 679,095			\$ 1,225,674	\$ * 546,579	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: 01/01/07 Ending: 12/31/07

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: 01/01/07

Ending: 12/31/07

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 6,620,619	19	\$ 44,100	\$	432,360	\$ 2,880	1
2	5	Utilities	Management Fee Income 6,620,619	19	20,208		432,360	1,320	2
3	6	Maintenance - Other	Management Fee Income 6,620,619	19	5,313		432,360	347	3
4	11	Activities-Special Events	Management Fee Income 6,620,619	19	6,306		432,360	412	4
5	17	Admin - Misc. Other	Management Fee Income 6,620,619	19	132,045		432,360	8,623	5
6	17	Administrative Salaries	Management Fee Income 6,620,619	19	2,163,976	2,163,976	432,360	141,319	6
7	19	Professional Services	Management Fee Income 6,620,619	19	728,345		432,360	47,565	7
8	20	Dues,Subscriptions	Management Fee Income 6,620,619	19	100,486		432,360	6,562	8
9	21	Clerical Supplies	Management Fee Income 6,620,619	19	109,877		432,360	7,176	9
10	22	Employee Benefits	Management Fee Income 6,620,619	19	584,930		432,360	38,199	10
11	23	Education/Conference	Management Fee Income 6,620,619	19	52,430		432,360	3,424	11
12	24	Travel	Management Fee Income 6,620,619	19	74,891		432,360	4,891	12
13	26	Insurance	Management Fee Income 6,620,619	19	13,824		432,360	903	13
14	30	Depreciation	Management Fee Income 6,620,619	19	39,013		432,360	2,548	14
15	32	Interest	Management Fee Income 6,620,619	19	2,207,136		432,360	144,137	15
16	34	Rent - Facility	Management Fee Income 6,620,619	19	179,713		432,360	11,736	16
17	35	Rent - Equipment	Management Fee Income 6,620,619	19	24,448		432,360	1,597	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,487,041	\$ 2,163,976		\$ 423,639	25

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/07

Ending: 12/31/07

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	1,239,804	10	\$ 995,585	\$ 995,585	110,640	\$ 88,846	1
2	22	Employee Benefits	Operating Expense	1,239,804	10	234,337		110,640	20,912	2
3	30	Depreciation	Operating Expense	1,239,804	10	1,087,913		110,640	97,085	3
4	19	Admin Consulting,Other	Operating Expense	1,239,804	10	1,023,231		110,640	91,313	4
5	17	Information Systems Salaries	Operating Expense	1,759,764	10	338,615	338,615	157,320	30,272	5
6	22	Information Systems Benefits	Operating Expense	1,759,764	10	77,649		157,320	6,942	6
7	17	Information Systems - Other	Operating Expense	1,759,764	10	2,248,393		157,320	201,003	7
8	17	Admin Salaries	Direct Cost	1,239,804	10	473,834	473,834	110,640	42,285	8
9	22	Employee Benefits	Direct Cost	1,239,804	10	111,529		110,640	9,953	9
10	17	Information Systems Salaries	Direct Cost	1,759,764	10	407,099	407,099	157,320	36,394	10
11	22	Information Systems Benefits	Direct Cost	1,759,764	10	95,822		157,320	8,566	11
12	6	Information Systems - Equip Main	Direct Cost	1,759,764	10	234,347		157,320	20,950	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					\$ 7,328,354	\$ 2,215,133		\$ 654,521	25

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning: 01/01/07

Ending: 12/31/07

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		\$	\$		411,135	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				\$	\$		411,135	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	Name of Lender	2		3	4	5	6		8	9	10					
		Related**					Monthly Payment Required	Date of Note				Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO									Original	Balance			
	A. Directly Facility Related															
	Long-Term															
1	Home Office Allocation						\$	\$			\$ 144,137	1				
2												2				
3												3				
4												4				
5												5				
	Working Capital															
6												6				
7												7				
8												8				
9	TOTAL Facility Related							\$	\$			\$ 144,137	9			
	B. Non-Facility Related*															
10												10				
11												11				
12												12				
13												13				
14	TOTAL Non-Facility Related							\$	\$			\$	14			
15	TOTALS (line 9+line14)							\$	\$			\$ 144,137	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.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 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 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 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 2007 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.

2006 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 2006 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 2006.

(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>611 Allen Ln, St. Charles, IL</u>	\$ <u>80,759.36</u>	\$ <u>80,759.36</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>80,759.36</u>	\$ <u>80,759.36</u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Provena Pine View Care Center

0043430 Report Period Beginning:

01/01/07 Ending:

12/31/07

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning:

01/01/07

Ending:

12/31/07

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	10,810	753	15	753		6,965	9
10	Various			2000	39,332	1,812	13	1,812		16,685	10
11	Various			2001	11,485	1,443	9	1,443		9,380	11
12	Various			2002	150,620	10,252	10	10,252		53,263	12
13	Various			2003	222,442	22,886	9	22,886		102,989	13
14											14
15	CARPET FOR LOBBY, A-WING			2004	6,791	1,358	5	1,358		4,754	15
16	INSTALL FIRE ALARM SYSTE			2004	1,964	196	10	196		687	16
17	COLLINS/AIKMAN MOISTURE			2004	455	46	10	46		159	17
18											18
19	SEALCOAT PARKING LOTS AN			2005	17,985	1,799	10	1,799		4,496	19
20	NEW FIRE DAMPER MOTORS			2005	4,686	469	10	469		1,406	20
21	FOYER W/ VIRGINIA TILE T			2005	2,390	120	20	120		359	21
22	PNEUMATIC OPERATOR PUSH			2005	1,496	150	10	150		374	22
23											23
24	35 REPLACEMENT WINDOWS			2006	29,750	2,975	10	2,975		4,463	24
25	FIRESTOP BASEMENT WALLS,			2006	7,532	753	10	753		1,130	25
26	10 NEW CONCRETE STEPS W/			2006	4,850	323	15	323		485	26
27	3 DOORS, HINGES AND LEVE			2006	2,780	185	15	185		278	27
28	BACK DOOR REPLACEMENT			2006	2,262	113	20	113		170	28
29											29
30	LOADING RAMP IMPROVEMENT			2007	21,500	1,344	8	2,688	1,344	1,344	30
31	FLOOD PREVENTION WORK,EX			2007	9,276	464	10	928	464	464	31
32	WATER SOFTENER EQUIPMENT			2007	8,675	434	10	868	434	434	32
33	GAZEBO 14' BOXCAR			2007	6,815	227	15	454	227	227	33
34	PIPED AND REWIRE 14 OUTL			2007	3,630	182	10	363	182	182	34
35	REPAIR ROOF FLASHING, HV			2007	3,459	173	10	346	173	173	35
36	VINYL FLOORING IN FAMILY			2007	1,500	75	10	150		75	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:

01/01/07

Ending:

12/31/07

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9					
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation					
37		\$	\$		\$	\$	\$	37				
38								38				
39								39				
40								40				
41								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)	\$	572,485	\$	48,530	\$	51,428	\$	2,823	\$	210,940	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: 01/01/07 Ending: 12/31/07

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	\$ 792,581	\$ 88,103	\$ 88,103	\$	10	\$ 510,322	71
72	Current Year Purchases	105,555	6,283	12,566	6,283	10	6,283	72
73	Fully Depreciated Assets	24,302				5	24,302	73
74	Home Office Allocation		99,633	99,633				74
75	TOTALS	\$ 922,438	\$ 194,019	\$ 200,302	\$ 6,283		\$ 540,907	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)	\$ 1,494,923	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 242,549	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 251,730	83**
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,181	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 751,847	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	<u>Home Office Allocation</u>				<u>11,736</u>			5
6								6
7	TOTAL				\$ <u>491,736</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>/2008</u>	\$ _____
13.	<u>/2009</u>	\$ _____
14.	<u>/2010</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: \$ 50,794 Description: Nursing \$38146, Dietary \$2030, Admin. \$9021, Home Office \$1597

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18					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:

01/01/07

Ending:

12/31/07

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	\$	3,175	\$ 171,443	\$	3,175	\$ 171,443	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		1,146	61,891		1,146	61,891	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		3,793	204,825		3,793	204,825	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				411,135		411,135	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			\$	8,114	\$ 438,159	\$ 411,135	8,114	\$ 849,294	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: 01/01/07

Ending:

12/31/07

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/07

(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	\$ 8,785,520	\$	1
2	Cash-Patient Deposits	113,303		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,176,143		3
4	Supply Inventory (priced at)	533,002		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,312		6
7	Other Prepaid Expenses	134,911		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,759,191	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,331,517		12
13	Land	6,751,685		13
14	Buildings, at Historical Cost	83,408,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,112,162		16
17	Accumulated Depreciation (book methods)	(49,944,144)		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>	120,120		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 65,780,207	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 86,539,398	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 4,826,767	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,861,673		28
29	Short-Term Notes Payable	42,163		29
30	Accrued Salaries Payable	2,756,052		30
31	Accrued Taxes Payable (excluding real estate taxes)	80,845		31
32	Accrued Real Estate Taxes(Sch.IX-B)	823,060		32
33	Accrued Interest Payable	41,064		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Due to Related Party</u>	817,281		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 11,248,905	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,247,620		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	338,908		42
Other Long-Term Liabilities(specify):				
43	<u>Conditional Asset Retirement</u>	450,209		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,036,737	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,285,642	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 73,253,756	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 86,539,398	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,502,583	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(2,361,850)	3
4	Adj. To reconcile consolidated equity & consolidated income	2,720,550	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,861,283	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(490,855)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(333,474)	9
10	Stock Options Exercised		10
11	Contributions and Grants	417,345	11
12	Expenditures for Specific Purposes	(200,543)	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)	\$ (607,527)	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)	\$ 73,253,756	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Pine View Care Center

0043430

Report Period Beginning: 01/01/07

Ending: 12/31/07

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	\$ 6,191,562	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,191,562	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	799,655	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 799,655	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	16,047	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	382,399	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	304	20
21	Other Medical Services		21
22	Laundry	8,650	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 407,400	23
D. Non-Operating Revenue			
24	Contributions	17,711	24
25	Interest and Other Investment Income***	14,205	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 31,916	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	196,687	28
28a	<u>Misc. Income</u>	5,193	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 201,880	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,632,413	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,284,498	31
32	Health Care	3,595,366	32
33	General Administration	2,116,780	33
B. Capital Expense			
34	Ownership	631,937	34
C. Ancillary Expense			
35	Special Cost Centers	411,135	35
36	Provider Participation Fee	65,520	36
D. Other Expenses (specify):			
37	<u>Loss on SOFA</u>	18,032	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,123,268	40
41	Income before Income Taxes (line 30 minus line 40)**	(490,855)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (490,855)	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:

01/01/07

Ending:

12/31/07

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	1,892	1,979	\$ 76,163	\$ 38.49	1
2	Assistant Director of Nursing	1,283	1,419	55,016	38.77	2
3	Registered Nurses	26,354	28,390	891,443	31.40	3
4	Licensed Practical Nurses	16,960	18,015	526,642	29.23	4
5	CNAs & Orderlies	79,216	83,453	1,105,236	13.24	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,884	2,080	42,056	20.22	9
10	Activity Assistants	5,791	6,149	58,961	9.59	10
11	Social Service Workers	1,902	2,072	46,809	22.59	11
12	Dietician	2,002	2,100	46,733	22.25	12
13	Food Service Supervisor	859	948	10,079	10.63	13
14	Head Cook	3,960	4,230	41,359	9.78	14
15	Cook Helpers/Assistants	21,507	22,388	187,098	8.36	15
16	Dishwashers					16
17	Maintenance Workers	3,743	4,026	71,301	17.71	17
18	Housekeepers	11,959	12,560	111,163	8.85	18
19	Laundry	1,930	2,059	19,054	9.25	19
20	Administrator	1,860	2,192	84,485	38.54	20
21	Assistant Administrator					21
22	Other Administrative	5,165	5,480	92,953	16.96	22
23	Office Manager	3,692	4,094	68,499	16.73	23
24	Clerical	5,325	5,566	45,323	8.14	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>	1,908	2,080	37,305	17.94	33
34	TOTAL (lines 1 - 33)	199,192	211,280	\$ 3,617,678 *	\$ 17.12	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	409	\$ 30,351	1,3	35
36	Medical Director	\$800/mo	8,400	9,3	36
37	Medical Records Consultant	12	690	10,3	37
38	Nurse Consultant	70	10,425	10,3	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	20	935	11,3	44
45	Social Service Consultant	10	564	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	521	\$ 51,365		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	824	\$ 42,836	10,3	50
51	Licensed Practical Nurses	154	6,163	10,3	51
52	Certified Nurse Assistants/Aides	415	10,373	10,3	52
53	TOTAL (lines 50 - 52)	1,393	\$ 59,372		53

Facility Name & ID Number Provena Pine View Care Center# 0043430Report Period Beginning: 01/01/07Ending: 12/31/07**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. Life Services Network \$5,127
- (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. \$ 46,368 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. \$ 65,520
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? No Indicate the amount. \$ N/A
- (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? N/A 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.