



Facility Name & ID Number Provena Pine View Care Center

# 0043430 Report Period Beginning: 01/01/08 Ending: 12/31/08

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	43,920	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	43,920	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,858	7,806	7,847	34,511	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,858	7,806	7,847	34,511	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.58%

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

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

N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES  NO

I. On what date did you start providing long term care at this location?

Date started 3/01/1998

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 7,847

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/08 Ending: 12/31/08

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
	<b>A. General Services</b>										
1	Dietary	309,605	41,120	46,067	396,792		396,792		396,792		1
2	Food Purchase		210,289		210,289		210,289	1,933	212,222		2
3	Housekeeping	115,516	17,913		133,429		133,429		133,429		3
4	Laundry	19,110	(692)	81,475	99,893		99,893		99,893		4
5	Heat and Other Utilities			174,510	174,510		174,510	2,302	176,812		5
6	Maintenance	85,217	22,407	83,407	191,031		191,031	31,182	222,213		6
7	Other (specify):*	35,951	41	4,877	40,869		40,869	4,773	45,642		7
8	<b>TOTAL General Services</b>	<b>565,399</b>	<b>291,078</b>	<b>390,336</b>	<b>1,246,813</b>		<b>1,246,813</b>	<b>40,190</b>	<b>1,287,003</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			19,955	19,955		19,955		19,955		9
10	Nursing and Medical Records	2,684,285	181,930	203,533	3,069,748		3,069,748		3,069,748		10
10a	Therapy			952,369	952,369		952,369		952,369		10a
11	Activities	104,177	1,415	5,728	111,320		111,320	463	111,783		11
12	Social Services	50,133		260	50,393		50,393		50,393		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,838,595</b>	<b>183,345</b>	<b>1,181,845</b>	<b>4,203,785</b>		<b>4,203,785</b>	<b>463</b>	<b>4,204,248</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	331,965	31,628	715,740	1,079,333		1,079,333	(284,507)	794,826		17
18	Directors Fees										18
19	Professional Services			11,785	11,785		11,785	40,881	52,666		19
20	Dues, Fees, Subscriptions & Promotions			36,635	36,635		36,635	(21,387)	15,248		20
21	Clerical & General Office Expenses			28,268	28,268		28,268	6,730	34,998		21
22	Employee Benefits & Payroll Taxes			854,787	854,787		854,787	204,456	1,059,243		22
23	Inservice Training & Education			11,386	11,386		11,386	2,467	13,853		23
24	Travel and Seminar			16,490	16,490		16,490	5,045	21,535		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			91,860	91,860		91,860	350	92,210		26
27	Other (specify):* <b>Bad Debt</b>			(1,527)	(1,527)		(1,527)	1,527			27
28	<b>TOTAL General Administration</b>	<b>331,965</b>	<b>31,628</b>	<b>1,765,424</b>	<b>2,129,017</b>		<b>2,129,017</b>	<b>(44,438)</b>	<b>2,084,579</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,735,959</b>	<b>506,051</b>	<b>3,337,605</b>	<b>7,579,615</b>		<b>7,579,615</b>	<b>(3,785)</b>	<b>7,575,830</b>		<b>29</b>

\*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: 01/01/08 Ending: 12/31/08

## 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	
	<b>D. Ownership</b>											
30	Depreciation			126,091	126,091		126,091	86,710	212,801			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							626,495	626,495			32
33	Real Estate Taxes			75,055	75,055		75,055		75,055			33
34	Rent-Facility & Grounds			480,000	480,000		480,000	15,554	495,554			34
35	Rent-Equipment & Vehicles			19,301	19,301		19,301	2,350	21,651			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			700,447	700,447		700,447	731,109	1,431,556			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			468,964	468,964		468,964	(231,992)	236,972			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,880	65,880		65,880		65,880			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			534,844	534,844		534,844	(231,992)	302,852			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,735,959	506,051	4,572,896	8,814,906		8,814,906	495,332	9,310,238			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: 01/01/08

Ending: 12/31/08

**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	(341)	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	4,394	30		9
10	Interest and Other Investment Income	(6,467)	32		10
11	Discounts, Allowances, Rebates & Refunds	(231,992)	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	1,527	27		24
25	Fund Raising, Advertising and Promotional	(27,162)	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	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (260,041)		\$	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)	750,600		34
35	Other- Attach Schedule	4,773		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 755,373		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 495,332		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.

		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

BHF USE ONLY					
48		49		50	51
					52

Provena Pine View Care Center

ID# 0043430

Report Period Beginning: 01/01/08

Ending: 12/31/08

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Misc	\$ 4,773	7	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	4,773		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Provena Pine View Care Center

# 0043430

Report Period Beginning:

01/01/08

Ending:

12/31/08

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(341)	2,274	0	0	0	0	0	0	0	0	0	1,933	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	2,302	0	0	0	0	0	0	0	0	0	2,302	5
6	Maintenance	0	1,048	30,134	0	0	0	0	0	0	0	0	31,182	6
7	Other (specify):*	4,773	0	0	0	0	0	0	0	0	0	0	4,773	7
8	<b>TOTAL General Services</b>	<b>4,432</b>	<b>5,624</b>	<b>30,134</b>	<b>0</b>	<b>40,190</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	463	0	0	0	0	0	0	0	0	0	463	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>463</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>463</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(260,033)	(24,474)	0	0	0	0	0	0	0	0	(284,507)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	24,230	16,651	0	0	0	0	0	0	0	0	40,881	19
20	Fees, Subscriptions & Promotions	(27,162)	5,775	0	0	0	0	0	0	0	0	0	(21,387)	20
21	Clerical & General Office Expenses	0	6,730	0	0	0	0	0	0	0	0	0	6,730	21
22	Employee Benefits & Payroll Taxes	0	43,137	161,319	0	0	0	0	0	0	0	0	204,456	22
23	Inservice Training & Education	0	2,467	0	0	0	0	0	0	0	0	0	2,467	23
24	Travel and Seminar	0	5,045	0	0	0	0	0	0	0	0	0	5,045	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	350	0	0	0	0	0	0	0	0	0	350	26
27	Other (specify):*	1,527	0	0	0	0	0	0	0	0	0	0	1,527	27
28	<b>TOTAL General Administration</b>	<b>(25,635)</b>	<b>(172,299)</b>	<b>153,496</b>	<b>0</b>	<b>(44,438)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(21,203)</b>	<b>(166,212)</b>	<b>183,630</b>	<b>0</b>	<b>(3,785)</b>	<b>29</b>							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Pine View Care Center

# 0043430

Report Period Beginning:

01/01/08 Ending:

12/31/08

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	4,394	0	82,316	0	0	0	0	0	0	0	0	86,710	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,467)	0	632,962	0	0	0	0	0	0	0	0	626,495	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	15,554	0	0	0	0	0	0	0	0	15,554	34
35	Rent-Equipment & Vehicles	0	0	2,350	0	0	0	0	0	0	0	0	2,350	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(2,073)</b>	<b>0</b>	<b>733,182</b>	<b>0</b>	<b>731,109</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(231,992)	0	0	0	0	0	0	0	0	0	0	(231,992)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>(231,992)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(231,992)</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(255,268)</b>	<b>(166,212)</b>	<b>916,812</b>	<b>0</b>	<b>495,332</b>	<b>45</b>							

Facility Name & ID Number Provena Pine View Care Center

# 0043430

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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%	\$ 2,274	\$ 2,274 1
2	V	5 Utilities		Provena Senior Services	100.00%	2,302	2,302 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	1,048	1,048 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	463	463 4
5	V	17 Admin - Misc. Other	409,320	Provena Senior Services	100.00%	(1,244)	(410,564) 5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	150,531	150,531 6
7	V	19 Professional Services		Provena Senior Services	100.00%	24,230	24,230 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	5,775	5,775 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	6,730	6,730 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	43,137	43,137 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,467	2,467 11
12	V	24 Travel		Provena Senior Services	100.00%	5,045	5,045 12
13	V	26 Insurance		Provena Senior Services	100.00%	350	350 13
14	Total		\$ 409,320			\$ 243,108	\$ * (166,212) 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: 01/01/08Ending: 12/31/08

## 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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		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%	\$ 2,273	\$ 2,273	15
16	V	32 Interest		Provena Senior Services	100.00%	197,060	197,060	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	15,554	15,554	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	2,350	2,350	18
19	V	17 Admin Salaries	120,060	Provena Health Services	100.00%	74,817	(45,243)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	56,937	56,937	20
21	V	30 Depreciation		Provena Health Services	100.00%	80,043	80,043	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	16,651	16,651	22
23	V	17 Information Systems Salaries	186,360	Provena Health Services	100.00%	129,879	(56,481)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	34,571	34,571	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	17,630	17,630	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	24,186	24,186	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	38,033	38,033	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	35,434	35,434	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	31,778	31,778	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	30,134	30,134	30
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	435,902	435,902	31
32	V	39 Ancillary Services - Other	468,964	Provena Senior Services Pharmacy	100.00%	468,964		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 775,384			\$ 1,692,196	\$ * 916,812	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: 01/01/08 Ending: 12/31/08

## 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: 01/01/08

Ending: 12/31/08

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 6,616,778	19	\$ 36,766	\$	409,320	\$ 2,274	1
2	5	Utilities	Management Fee Income 6,616,778	19	37,212		409,320	2,302	2
3	6	Maintenance - Other	Management Fee Income 6,616,778	19	16,939		409,320	1,048	3
4	11	Activities-Special Events	Management Fee Income 6,616,778	19	7,482		409,320	463	4
5	17	Admin - Misc. Other	Management Fee Income 6,616,778	19	(20,102)		409,320	(1,244)	5
6	17	Administrative Salaries	Management Fee Income 6,616,778	19	2,433,377	2,433,377	409,320	150,531	6
7	19	Professional Services	Management Fee Income 6,616,778	19	391,693		409,320	24,230	7
8	20	Dues,Subscriptions	Management Fee Income 6,616,778	19	93,352		409,320	5,775	8
9	21	Clerical Supplies	Management Fee Income 6,616,778	19	108,789		409,320	6,730	9
10	22	Employee Benefits	Management Fee Income 6,616,778	19	697,316		409,320	43,137	10
11	23	Education/Conference	Management Fee Income 6,616,778	19	39,879		409,320	2,467	11
12	24	Travel	Management Fee Income 6,616,778	19	81,549		409,320	5,045	12
13	26	Insurance	Management Fee Income 6,616,778	19	5,664		409,320	350	13
14	30	Depreciation	Management Fee Income 6,616,778	19	36,741		409,320	2,273	14
15	32	Interest	Management Fee Income 6,616,778	19	3,185,539		409,320	197,060	15
16	34	Rent - Facility	Management Fee Income 6,616,778	19	251,434		409,320	15,554	16
17	35	Rent - Equipment	Management Fee Income 6,616,778	19	37,982		409,320	2,350	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 7,441,612	\$ 2,433,377		\$ 460,345	25

Facility Name & ID Number Provena Pine View Care Center

# 0043430

Report Period Beginning: 01/01/08

Ending: 12/31/08

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	1,391,394	9	\$ 867,070	\$ 867,070	120,060	\$ 74,817	1
2	22	Employee Benefits	Operating Expense	1,391,394	9	659,854		120,060	56,937	2
3	30	Depreciation	Operating Expense	1,391,394	9	927,633		120,060	80,043	3
4	34	Rent Facility	Operating Expense	1,391,394	9	192,975		120,060	16,651	4
5	19	Admin Consulting,Other	Operating Expense	1,391,394	9	1,505,183		120,060	129,879	5
6	17	Information Systems Salaries	Operating Expense	2,155,920	9	399,935	399,935	186,360	34,571	6
7	22	Information Systems Benefits	Operating Expense	2,155,920	9	203,956		186,360	17,630	7
8	17	Information Systems - Other	Operating Expense	2,155,920	9	279,796		186,360	24,186	8
9	17	Admin Salaries	Direct Cost	1,391,394	9	440,776	440,776	120,060	38,033	9
10	17	Information Systems Salaries	Direct Cost	2,155,920	9	409,925	409,925	186,360	35,434	10
11	6	Information Systems - Equip Main	Direct Cost	2,155,920	9	367,627		186,360	31,778	11
12	19	Admin Consulting,Other	Direct Cost	1,391,394	9	349,224		120,060	30,134	12
13	32	Admin - Interest Expense	Direct Cost	1,391,394	9	5,051,741		120,060	435,902	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					\$ 11,655,695	\$ 2,117,706		\$ 1,005,995	25

Facility Name & ID Number Provena Pine View Care Center

# 0043430

Report Period Beginning: 01/01/08

Ending: 12/31/08

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		\$	\$		\$ 468,964	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				\$	\$		\$ 468,964	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			
<b>A. Directly Facility Related</b>																
<b>Long-Term</b>																
1	Home Office Allocation						\$	\$			\$ 197,060					
2																
3																
4																
5																
<b>Working Capital</b>																
6																
7																
8																
9	<b>TOTAL Facility Related</b>						\$	\$			\$ 197,060					
<b>B. Non-Facility Related*</b>																
10																
11																
12																
13																
14	<b>TOTAL Non-Facility Related</b>						\$	\$								
15	<b>TOTALS (line 9+line14)</b>						\$	\$			\$ 197,060					

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:** 2007 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 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 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 2008 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.

**2007 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 2007 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 2007.

(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>81,931.88</u>	\$ <u>81,931.88</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>81,931.88</u>	\$ <u>81,931.88</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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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:

01/01/08 Ending:

12/31/08

**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).

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

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

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

**XI. OWNERSHIP COSTS:**

A. Land.

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

Facility Name &amp; ID Number Provena Pine View Care Center

# 0043430

Report Period Beginning:

01/01/08

Ending:

12/31/08

**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
	<b>Improvement Type**</b>										
9	Various		1999		6,570	611	20	611		3,478	9
10	Various		2000		36,234	1,812	20	1,812		15,399	10
11	Various		2001		11,485	952	9	952		10,333	11
12	Various		2002		144,300	9,774	7	9,774		57,720	12
13	Various		2003		222,442	21,414	9	21,414		123,763	13
14	Various		2004		9,210	1,600	8	1,600		7,200	14
15											15
16	SEALCOAT PARKING LOTS AN		2005		17,985	1,799	10	1,799		6,295	16
17	NEW FIRE DAMPER MOTORS		2005		4,686	469	10	469		1,874	17
18	FOYER W/ VIRGINIA TILE T		2005		2,390	120	20	120		478	18
19	PNEUMATIC OPERATOR PUSH		2005		1,496	150	10	150		524	19
20											20
21	35 REPLACEMENT WINDOWS		2006		29,750	2,975	10	2,975		7,438	21
22	FIRESTOP BASEMENT WALLS,		2006		7,532	753	10	753		1,883	22
23	10 NEW CONCRETE STEPS W/		2006		4,850	323	15	323		808	23
24	3 DOORS, HINGES AND LEVE		2006		2,780	185	15	185		463	24
25	BACK DOOR REPLACEMENT		2006		2,262	113	20	113		283	25
26											26
27	LOADING RAMP IMPROVEMENT		2007		21,500	2,688	8	2,688		4,031	27
28	FLOOD PREVENTION WORK,EX		2007		9,276	928	10	928		1,391	28
29	WATER SOFTENER EQUIPMENT		2007		8,675	868	10	868		1,301	29
30	GAZEBO 14' BOXCAR		2007		6,815	454	15	454		682	30
31	PIPED AND REWIRE 14 OUTL		2007		3,630	363	10	363		545	31
32	REPAIR ROOF FLASHING, HV		2007		3,459	346	10	346		519	32
33	VINYL FLOORING IN FAMILY		2007		1,500	150	10	150		225	33
34	CARPET AND VINYL BASE FOR 5 RESIDENTS		2007		5,750	1,150	5	1,150		1,150	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:

01/01/08

Ending:

12/31/08

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	SUMP PRO BATTERY BACK-UP AND WEIL UP	2008	13,934	697	10	1,393	697	697	38
39	HOT WATER STORAGE TANK	2008	8,338	208	20	417	208	208	39
40	ASHPALT FOR WEST PARKING LOT	2008	2,695	168	8	337	168	168	40
41	FIRST IMPRESSIONS PROJECT	2008	8,357	418	10	836	418	418	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)		\$ 597,901	\$ 51,487		\$ 52,979	\$ 1,491	\$ 249,275	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: 01/01/08 Ending: 12/31/08

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	\$ 886,007	\$ 71,701	\$ 71,701	\$	10	\$ 554,120	71
72	Current Year Purchases	46,448	2,903	5,805	2,903	10	2,903	72
73	Fully Depreciated Assets	11,659				5	11,659	73
74	Home Office Allocation		82,316	82,316				74
75	TOTALS	\$ 944,113	\$ 156,920	\$ 159,822	\$ 2,903		\$ 568,681	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)	\$ 1,542,014	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 208,407	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 212,801	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,394	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 817,955	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>15,554</u>			5
6								6
7	TOTAL				\$ <u>495,554</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>/2009</u>	\$ _____
13.	<u>/2010</u>	\$ _____
14.	<u>/2011</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: \$ 49,093 Description: Nursing \$26,166; Dietary \$1,276; Administration \$19,301; Home Office \$2,350

(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.

Facility Name & ID Number Provena Pine View Care Center # 0043430 Report Period Beginning: 01/01/08 Ending: 12/31/08

**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)	
<b>TOTAL TRAINED</b>	

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

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

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

Report Period Beginning:

01/01/08

Ending:

12/31/08

## 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	\$	6,469	\$ 400,687	\$	6,469	\$ 400,687	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,363	85,326		1,363	85,326	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		7,568	466,356		7,568	466,356	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 prescripts				468,964		468,964	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	<b>TOTAL</b>			\$	15,400	\$ 952,369	\$ 468,964	15,400	\$ 1,421,333	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: 01/01/08

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## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 7,556,064	\$	1
2	Cash-Patient Deposits	112,800		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	14,518,279		3
4	Supply Inventory (priced at )	609,759		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,320		6
7	Other Prepaid Expenses	150,561		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 22,969,783	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,624,013		12
13	Land	6,742,855		13
14	Buildings, at Historical Cost	84,767,866		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,707,364		16
17	Accumulated Depreciation (book methods)	(52,758,206)		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>	113,256		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 64,197,148	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 87,166,931	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 4,366,203	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,621,117		28
29	Short-Term Notes Payable	50,318		29
30	Accrued Salaries Payable	3,252,222		30
31	Accrued Taxes Payable (excluding real estate taxes)	103,086		31
32	Accrued Real Estate Taxes(Sch.IX-B)	935,960		32
33	Accrued Interest Payable	29,590		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>Due to Related Party</u>	1,231,737		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 11,590,233	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,218,868		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	289,981		42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>Conditional Asset Retirement</u>	438,744		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,947,593	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 13,537,826	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,629,105	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 87,166,931	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,253,756	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(358,099)	3
4	Adj. To reconcile consolidated equity & consolidated income	877,201	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,772,858	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(583,166)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	683,319	11
12	Expenditures for Specific Purposes	(243,906)	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)	\$ (143,753)	17
	<b>B. Transfers (Itemize):</b>		
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)	\$ 73,629,105	24 *

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

Facility Name & ID Number Provena Pine View Care Center# 0043430Report Period Beginning: 01/01/08Ending: 12/31/08**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	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,872,942	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,872,942	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,614,942	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,614,942	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,145	13
14	Non-Patient Meals	341	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	466,306	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	170	20
21	Other Medical Services		21
22	Laundry	15,625	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 499,587	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	14,068	24
25	Interest and Other Investment Income***	6,467	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 20,535	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Purchase Rebates</b>	231,992	28
28a	<b>Misc Income &amp; Gain/Loss SOFA</b>	(8,258)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 223,734	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,231,740	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,246,813	31
32	Health Care	4,203,785	32
33	General Administration	2,129,017	33
<b>B. Capital Expense</b>			
34	Ownership	700,447	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	468,964	35
36	Provider Participation Fee	65,880	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,814,906	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(583,166)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (583,166)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ 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

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Ending:

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**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	2,080	\$ 84,878	\$ 40.81	1
2	Assistant Director of Nursing	984	1,000	39,028	39.03	2
3	Registered Nurses	25,758	28,339	831,365	29.34	3
4	Licensed Practical Nurses	16,181	17,394	379,013	21.79	4
5	CNAs & Orderlies	73,544	78,619	1,319,057	16.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,997	2,084	30,944	14.85	8
9	Activity Director	1,912	2,080	42,490	20.43	9
10	Activity Assistants	6,107	6,586	61,687	9.37	10
11	Social Service Workers	1,924	2,080	50,133	24.10	11
12	Dietician	1,928	2,080	40,982	19.70	12
13	Food Service Supervisor	1,567	1,618	19,155	11.84	13
14	Head Cook	5,472	5,876	61,025	10.39	14
15	Cook Helpers/Assistants	19,503	20,464	188,442	9.21	15
16	Dishwashers					16
17	Maintenance Workers	4,618	4,951	85,217	17.21	17
18	Housekeepers	11,410	12,611	115,516	9.16	18
19	Laundry	1,782	1,979	19,110	9.66	19
20	Administrator	1,880	2,080	87,699	42.16	20
21	Assistant Administrator	152	160	4,854	30.34	21
22	Other Administrative	8,231	8,635	149,498	17.31	22
23	Office Manager	1,824	2,080	45,033	21.65	23
24	Clerical	4,711	4,895	44,882	9.17	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</u>	1,784	1,920	35,951	18.72	33
34	TOTAL (lines 1 - 33)	195,173	209,611	\$ 3,735,959 *	\$ 17.82	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	586	\$ 39,309	1,3	35
36	Medical Director	\$800/mo	8,800	9,3	36
37	Medical Records Consultant	23	2,134	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	16	1,051	11,3	44
45	Social Service Consultant	4	260	12,3	45
46	Other(specify)				46
47	<u>Rehabilitation Medical Director</u>	45	6,675	9,3	47
48					48
49	TOTAL (lines 35 - 48)	674	\$ 58,229		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses	1,825	\$ 97,618	10,3	50
51	Licensed Practical Nurses	20	964	10,3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	1,845	\$ 98,582		53

Facility Name & ID Number Provena Pine View Care Center

# 0043430

Report Period Beginning: 01/01/08

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**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	\$ 87,699	Workers' Compensation Insurance	\$ 109,680	IDPH License Fee	\$	
Administrative Staff	Admissions	0	105,649	Unemployment Compensation Insurance	11,737	Advertising: Employee Recruitment		
Administrative Staff	Human Resources	0	43,848	FICA Taxes	269,404	Health Care Worker Background Check		
Administrative Staff	Beautician	0	13,041	Employee Health Insurance	311,168	(Indicate # of checks performed <u>93</u> )		
Administrative Staff	Receptionist	0	31,841	Employee Meals		Patient Background Checks <u>225</u>		
Administrative Staff	Office Manager	0	45,033	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	678	
Administrative Staff	Asst. Administrator	0	4,854	Life Insurance	15,203	Dues & Subscription	9,697	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	115,003	Advertising & Public Relations	26,260	
(List each licensed administrator separately.)			\$ 331,965	Employee Recognition	2,515			
B. Administrative - Other				Executive Benefits	7,109	Home Office Allocation	5,775	
Description			Amount	Employee Screenings	12,968	Less: Public Relations Expense	( )	
Corp Service Fee			\$ 120,060	Home Office Allocation	204,456	Non-allowable advertising	(27,162)	
Corp Service IS Fee			186,360			Yellow page advertising	( )	
Mgmt Fee			372,960	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,059,243	
Mgmt Fee Interest			36,360	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 715,740	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		\$ 3,254	Out-of-State Travel			\$	
Shredding/Storage	Various		3,887					
Survey & Analytical Tools	Various		1,606	In-State Travel			16,490	
Copier Service	Various		1,986					
Background Checks	Various			Seminar Expense				
Collection Expense	Various		169	Home Office Allocation			5,045	
Outsourced Services	Various		883	Entertainment Expense			( )	
				(agree to Sch. V, line 24, col. 8)				
				TOTAL			\$ 21,535	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 11,785					

\* 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. Life Service Network \$5739
- (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. \$ 43,596 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 65,880  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 341
- (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.