

		FOR OFF USE				

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043448

Facility Name: Provena Geneva Care Center

Address: 1101 East State Street Geneva 60134
 Number City Zip Code

County: Kane

Telephone Number: (630) 232-7544 **Fax #** (630) 232.4409

IDPA ID Number: 371127787005

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

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code <u>501 C3</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

Facility Name & ID Number Provena Geneva Care Center

0043448 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 07/01/05

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>13</u>	Skilled (SNF)	<u>34</u>	<u>8,609</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>94</u>	Intermediate (ICF)	<u>73</u>	<u>26,645</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>107</u>	TOTALS	<u>107</u>	<u>35,254</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>5,484</u>	<u>2,722</u>	<u>8,206</u>	8
9	SNF/PED					9
10	ICF	<u>22,936</u>	<u>3,656</u>		<u>26,592</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>22,936</u>	<u>9,140</u>	<u>2,722</u>	<u>34,798</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 98.71%

D. How many bed-hold days during this year were paid by the Department?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

N/A - None

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

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

YES NO

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

YES NO

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

Date started 3/1/1998

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

YES Date 3/1/1998 NO

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

YES NO If YES, enter number of beds certified 34 and days of care provided 2,722

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	204,577	28,672	15,512	248,761		248,761		248,761			1
2	Food Purchase		173,434		173,434		173,434	3,030	176,464			2
3	Housekeeping	71,594	8,629		80,223		80,223		80,223			3
4	Laundry	30,347	1,401	85,558	117,306		117,306		117,306			4
5	Heat and Other Utilities			80,342	80,342		80,342	1,682	82,024			5
6	Maintenance	47,517	8,347	48,125	103,989		103,989	28,789	132,778			6
7	Other (specify):* Pastoral Care/Dev.	18,722	668	584	19,974		19,974	(502)	19,472			7
8	TOTAL General Services	372,757	221,151	230,121	824,029		824,029	32,999	857,028			8
	B. Health Care and Programs											
9	Medical Director			6,225	6,225		6,225		6,225			9
10	Nursing and Medical Records	2,037,544	69,603	48,918	2,156,065		2,156,065		2,156,065			10
10a	Therapy			161,451	161,451		161,451		161,451			10a
11	Activities	96,981	6,403	11,012	114,396		114,396	1,845	116,241			11
12	Social Services	39,106	20	550	39,676		39,676		39,676			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,173,631	76,026	228,156	2,477,813		2,477,813	1,845	2,479,658			16
	C. General Administration											
17	Administrative	213,305	14,179	681,600	909,084		909,084	(356,065)	553,019			17
18	Directors Fees											18
19	Professional Services			23,097	23,097		23,097	176,146	199,243			19
20	Dues, Fees, Subscriptions & Promotions			46,650	46,650		46,650	(19,477)	27,173			20
21	Clerical & General Office Expenses			34,636	34,636		34,636	1,336	35,972			21
22	Employee Benefits & Payroll Taxes			619,699	619,699		619,699	101,529	721,228			22
23	Inservice Training & Education			6,298	6,298		6,298	5,647	11,945			23
24	Travel and Seminar			7,843	7,843		7,843	6,307	14,150			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			70,072	70,072		70,072	6,775	76,847			26
27	Other (specify):* Bad Debt			88,447	88,447		88,447	(88,447)				27
28	TOTAL General Administration	213,305	14,179	1,578,342	1,805,826		1,805,826	(166,249)	1,639,577			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,759,693	311,356	2,036,619	5,107,668		5,107,668	(131,405)	4,976,263			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 Geneva Care Center #0043448 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			333,666	333,666		333,666	59,215	392,881			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							195,948	195,948			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							16,919	16,919			34
35	Rent-Equipment & Vehicles			2,861	2,861		2,861	896	3,757			35
36	Other (specify):*											36
37	TOTAL Ownership			336,527	336,527		336,527	272,978	609,505			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			162,650	162,650		162,650		162,650			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,743	58,743		58,743		58,743			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			221,393	221,393		221,393		221,393			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,759,693	311,356	2,594,539	5,665,588		5,665,588	141,573	5,807,161			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 Geneva Care Center

0043448

Report Period Beginning: 01/01/05

Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				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	7,828	30		9
10	Interest and Other Investment Income	(4)	32		10
11	Discounts, Allowances, Rebates & Refunds	(12,033)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(88,447)	27		24
25	Fund Raising, Advertising and Promotional	(29,556)	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)	\$ (122,212)		\$	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)	264,287		34
35	Other- Attach Schedule	(502)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 263,785		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 141,573		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

OHF USE ONLY					
48		49		50	
				51	
					52

Provena Geneva Care Center

ID# 0043448

Report Period Beginning: 01/01/05

Ending: 12/31/05

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Misc	\$ (502)	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	Total	(502)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	3,030	0	0	0	0	0	0	0	0	0	3,030	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	1,682	0	0	0	0	0	0	0	0	0	1,682	5
6	Maintenance	0	591	28,198	0	0	0	0	0	0	0	0	28,789	6
7	Other (specify):*	(502)	0	0	0	0	0	0	0	0	0	0	(502)	7
8	TOTAL General Services	(502)	5,303	28,198	0	32,999	8							
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,845	0	0	0	0	0	0	0	0	0	1,845	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	1,845	0	0	0	0	0	0	0	0	0	1,845	16
	C. General Administration													
17	Administrative	0	(339,668)	(16,397)	0	0	0	0	0	0	0	0	(356,065)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	33,827	142,319	0	0	0	0	0	0	0	0	176,146	19
20	Fees, Subscriptions & Promotions	(29,556)	10,079	0	0	0	0	0	0	0	0	0	(19,477)	20
21	Clerical & General Office Expenses	(12,033)	13,369	0	0	0	0	0	0	0	0	0	1,336	21
22	Employee Benefits & Payroll Taxes	0	54,195	47,334	0	0	0	0	0	0	0	0	101,529	22
23	Inservice Training & Education	0	5,647	0	0	0	0	0	0	0	0	0	5,647	23
24	Travel and Seminar	0	6,307	0	0	0	0	0	0	0	0	0	6,307	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	6,775	0	0	0	0	0	0	0	0	0	6,775	26
27	Other (specify):*	(88,447)	0	0	0	0	0	0	0	0	0	0	(88,447)	27
28	TOTAL General Administration	(130,036)	(209,469)	173,256	0	(166,249)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(130,538)	(202,321)	201,454	0	(131,405)	29							

STATE OF ILLINOIS

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/05 Ending:

Summary B

12/31/05

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	7,828	0	51,387	0	0	0	0	0	0	0	0	59,215	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4)	0	195,952	0	0	0	0	0	0	0	0	195,948	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	16,919	0	0	0	0	0	0	0	0	16,919	34
35	Rent-Equipment & Vehicles	0	0	896	0	0	0	0	0	0	0	0	896	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	7,824	0	265,154	0	272,978	37							
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(122,714)	(202,321)	466,608	0	141,573	45							

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/05

Ending:

12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 3,030	\$ 3,030
2	V	5 Utilities		Provena Senior Services	100.00%	1,682	1,682
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	591	591
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	1,845	1,845
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	15,803	15,803
6	V	17 Administrative Salaries	552,000	Provena Senior Services	100.00%	196,529	(355,471)
7	V	19 Professional Services		Provena Senior Services	100.00%	33,827	33,827
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	10,079	10,079
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	13,369	13,369
10	V	22 Employee Benefits		Provena Senior Services	100.00%	54,195	54,195
11	V	23 Education/Conference		Provena Senior Services	100.00%	5,647	5,647
12	V	24 Travel		Provena Senior Services	100.00%	6,307	6,307
13	V	26 Insurance		Provena Senior Services	100.00%	6,775	6,775
14	Total		\$ 552,000			\$ 349,679	\$ * (202,321)

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 3,213	\$ 3,213	15
16	V	32 Interest		Provena Senior Services	100.00%	195,952	195,952	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	16,919	16,919	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	896	896	18
19	V	17 Admin Salaries	76,800	Provena Health Services	100.00%	50,501	(26,299)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	21,116	21,116	20
21	V	30 Depreciation		Provena Health Services	100.00%	48,174	48,174	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	142,319	142,319	22
23	V	17 Information Systems Salaries	52,800	Provena Health Services	100.00%	11,407	(41,393)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	4,770	4,770	24
25	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	5,088	5,088	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	31,518	31,518	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	13,179	13,179	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	19,777	19,777	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	8,269	8,269	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	23,110	23,110	30
31	V	39 Ancillary Services - Other	162,650	Provena Senior Services Pharmacy	100.00%	162,650		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 292,250			\$ 758,858	\$ * 466,608	39

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income 5,261,654	20	\$ 28,878	\$	552,000	\$ 3,030	1
2	5	Utilities	Management Fee Income 5,261,654	20	16,037		552,000	1,682	2
3	6	Maintenance - Other	Management Fee Income 5,261,654	20	5,629		552,000	591	3
4	11	Activities-Special Events	Management Fee Income 5,261,654	20	17,583		552,000	1,845	4
5	17	Admin - Misc. Other	Management Fee Income 5,261,654	20	150,633		552,000	15,803	5
6	17	Administrative Salaries	Management Fee Income 5,261,654	20	1,873,311	1,873,311	552,000	196,529	6
7	19	Professional Services	Management Fee Income 5,261,654	20	322,442		552,000	33,827	7
8	20	Dues,Subscriptions	Management Fee Income 5,261,654	20	96,069		552,000	10,079	8
9	21	Clerical Supplies	Management Fee Income 5,261,654	20	127,431		552,000	13,369	9
10	22	Employee Benefits	Management Fee Income 5,261,654	20	516,585		552,000	54,195	10
11	23	Education/Conference	Management Fee Income 5,261,654	20	53,828		552,000	5,647	11
12	24	Travel	Management Fee Income 5,261,654	20	60,116		552,000	6,307	12
13	26	Insurance	Management Fee Income 5,261,654	20	64,582		552,000	6,775	13
14	30	Depreciation	Management Fee Income 5,261,654	20	30,629		552,000	3,213	14
15	32	Interest	Management Fee Income 5,261,654	20	1,867,812		552,000	195,952	15
16	34	Rent - Facility	Management Fee Income 5,261,654	20	161,270		552,000	16,919	16
17	35	Rent - Equipment	Management Fee Income 5,261,654	20	8,543		552,000	896	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 5,401,378	\$ 1,873,311		\$ 566,659	25

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,146,264	10	\$ 753,738	\$ 753,738	76,800	\$ 50,501	1
2	22	Employee Benefits	Operating Expense	1,146,264	10	315,161		76,800	21,116	2
3	30	Depreciation	Operating Expense	1,146,264	10	719,013		76,800	48,174	3
4	19	Admin Consulting,Other	Operating Expense	1,146,264	10	2,124,158		76,800	142,319	4
5	17	Information Systems Salaries	Operating Expense	791,616	10	171,021	171,021	52,800	11,407	5
6	22	Information Systems Benefits	Operating Expense	791,616	10	71,509		52,800	4,770	6
7	6	Information Systems - Equip Main	Operating Expense	791,616	10	76,287		52,800	5,088	7
8	17	Admin Salaries	Direct Cost	1,146,264	10	470,416	470,416	76,800	31,518	8
9	22	Employee Benefits	Direct Cost	1,146,264	10	196,696		76,800	13,179	9
10	17	Information Systems Salaries	Direct Cost	791,616	10	296,512	296,512	52,800	19,777	10
11	22	Information Systems Benefits	Direct Cost	791,616	10	123,981		52,800	8,269	11
12	6	Information Systems - Equip Main	Direct Cost	791,616	10	346,486		52,800	23,110	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,664,978	\$ 1,691,687		\$ 379,228	25

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/05

Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 162,650	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				\$	\$		\$ 162,650	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
Working Capital																				
6										6										
7										7										
8										8										
9	TOTAL Facility Related					\$	\$		\$	9										
B. Non-Facility Related*																				
10	Provena Senior Services									195,948	10									
11										11										
12										12										
13										13										
14	TOTAL Non-Facility Related					\$	\$		\$	195,948	14									
15	TOTALS (line 9+line14)					\$	\$		\$	195,948	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:** 2004 REAL ESTATE TAX COST DOCUMENTATION

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

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

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

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena Geneva Care Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0043448

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

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

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

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

Facility Name & ID Number Provena Geneva Care Center

0043448 Report Period Beginning:

01/01/05 Ending:

12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

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

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

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

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

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

None

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	107		1998		\$ 5,000,000	\$ 166,667	30	\$ 166,667		\$ 1,250,000	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1999		13,966	1,222	8	1,222		10,300	9
10	Various		2000		5,712	571	10	571		3,142	10
11	Various		2001		638,937	25,785	15	25,785		116,944	11
12											12
13		DESC: PLUMBING - PIPE REPLACEMENT	2002		544	22	25	22		76	13
14		DESC: CARPETING	2002		824	165	5	165		494	14
15		DESC: MURAL FOR VISTA AREA	2002		4,500	643	7	643		1,929	15
16		DESC: MURALS IN VISTA UNIT	2002		2,250	450	5	450		1,575	16
17											17
18		DESC: KJWW ENGINEERING CONSULTANT	2003		1,767	353	5	353		883	18
19		DESC: CARPETING	2003		824	55	15	55		137	19
20		DESC: CORNICE	2003		785	157	5	157		393	20
21		DESC: REPLACEMENT OF GAS AIR MAKE-UP UNIT	2003		15,843	1,056	15	1,056		2,641	21
22		DESC: CORNER CORNICE	2003		595	119	5	119		298	22
23		DESC: PARKING LOT RENOVATION	2003		8,115	812	10	812		2,029	23
24		DESC: FIRE DAMPERS	2003		7,452	497	15	497		1,242	24
25		DESC: LANDSCAPING FOR 1/3 OF COURTYARD	2003		2,575	258	10	258		644	25
26		DESC: WASTE DRAINS	2003		14,952	1,495	10	1,495		3,738	26
27		DESC: OUTSIDE PORCH AREA SPRINKLER	2003		7,900	790	10	790		1,975	27
28		DESC: BACKFLOW PREVENTER FOR SPRINKLER SYS	2003		6,850	685	10	685		1,713	28
29		DESC: VENT AND EJECTOR SYSTEM FOR KITCHEN	2003		3,506	351	10	351		877	29
30		DESC: KITCHEN TILE	2003		3,053	204	15	204		509	30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/05

Ending:

12/31/05

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	DESC: CUSTOM INSIGNIA	2004	\$ 3,845	\$ 385	10	\$ 385	\$	\$ 577	37
38	DESC: NEW SHOWERS	2004	9,000	900	10	900		1,350	38
39	DESC: BRASS KNOB LOCKSET	2004	1,580	158	10	158		237	39
40	DESC: LOCKSET	2004	593	59	10	59		87	40
41	DESC: DESIGN FOR CONVERSION UNIT	2004	246	49	5	49		49	41
42	DESC: REPLACEMENT OF BATHTUBS WITH SHOWERS	2004	11,463	1,146	10	1,146		1,719	42
43	DESC: ANSUL SUPPRESSION SYSTEM ABOVE STOVE	2004	1,898	190	10	190		285	43
44	DESC: 2ND FLOOR NURSES STATION	2004	5,280	264	20	264		396	44
45	DESC: SWITCH BOARD	2004	1,937	194	10	194		291	45
46	DESC: ELEVATOR REPAIRS	2004	5,990	300	20	300		449	46
47	DESC: CUPOLA AND CURB FLASHING REPLACEMENT	2004	6,890	689	10	689		1,034	47
48	DESC: LANDSCAPING	2004	7,077	708	10	708		1,062	48
49	DESC: HOT WATER PIPE REPAIRS	2004	1,851	370	5	370		555	49
50	DESC: NEW PHONE SYSTEM	2004	19,567	1,957	10	1,957		2,230	50
51	DESC: CARPET FOR LOBBY, CORRIDOR, LOUNGE &	2004	32,460	6,492	5	6,492		6,492	51
52	DESC: PERSONALIZED BRICKS FOR COURTYARD	2004	675	68	10	68		68	52
53	DESC: ROOF REPAIR FOR LEAKS	2004	2,800	280	10	280		420	53
54	DESC: REPLACEMENT OF DUCT WORK / REPAIR OF	2004	745	149	5	149		149	54
55									55
56	DESC: TEKNOFLOR FOR DINING ROOM	2005	19,900	995	10	1,990	995	1,990	56
57	DESC: GREASE TRAP	2005	1,625	81	10	163	81	163	57
58	DESC: MASONRY RESTORATION	2005	4,375	438	5	875	438	875	58
59	DESC: INSTALL 5 THERMOSTATS	2005	933	47	10	93	47	93	59
60	DESC: REPLACE KITCHEN ISLAND	2005	15,571	779	10	1,557	779	1,557	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)		\$ 5,897,250	\$ 219,050		\$ 221,388	\$ 2,339	\$ 1,423,663	70

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,041,229	\$ 108,856	\$ 108,856		8	\$ 693,754	71
72	Current Year Purchases	102,755	5,761	11,250	5,489	9	11,250	72
73	Fully Depreciated Assets	39,499					39,499	73
74	Home Office Allocation		51,387	51,387				74
75	TOTALS	\$ 1,183,482	\$ 166,004	\$ 171,493	\$ 5,489		\$ 744,502	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)	\$ 7,080,732	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 385,053	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 392,881	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,828	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,168,165	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: N/A

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

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Home office allocation				16,919			5
6								6
7	TOTAL				\$ 16,919			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.	_____ /2006	\$ _____
13.	_____ /2007	\$ _____
14.	_____ /2008	\$ _____

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: \$ 33,699 Description: Nursing - \$26,492.65, Activities - \$83.40, Dietary - \$1,538.75, Plant Eng - \$551.47, Laundry - \$1,276, Admin - \$
(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	n/a		\$	\$	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 Geneva Care Center # 0043448 Report Period Beginning: 01/01/05 Ending: 12/31/05

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

Facility Name & ID Number Provena Geneva Care Center# 0043448

Report Period Beginning:

01/01/05

Ending:

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	1,321	\$ 68,948	\$	1,321	\$ 68,948	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		125	6,533		125	6,533	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		1,647	85,970		1,647	85,970	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				162,650		162,650	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			\$	3,093	\$ 161,451	\$ 162,650	3,093	\$ 324,101	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 Geneva Care Center# 0043448Report Period Beginning: 01/01/05

Ending:

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XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 10,947,364	\$	1
2	Cash-Patient Deposits	102,762		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,022,174		3
4	Supply Inventory (priced at)	562,029		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,455		6
7	Other Prepaid Expenses	234,588		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 19,922,372	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,323,187		12
13	Land	6,872,845		13
14	Buildings, at Historical Cost	79,429,531		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	15,136,519		16
17	Accumulated Depreciation (book methods)	(44,514,067)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	133,848		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 65,381,863	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 85,304,235	\$	25

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 72,625,309	1
2	Restatements (describe):		2
3	FAS47 Change in accounting principal	(271,871)	3
4	Adj. To Reconcile Consolidated Equity and Consolidated	2,956,759	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 75,310,197	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(586,629)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised	(40,261)	10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes	240,328	12
13	Dividends Paid or Other Distributions to Owners	(170,420)	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)	\$ (556,982)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 74,753,215	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Geneva Care Center# 0043448Report Period Beginning: 01/01/05Ending: 12/31/05**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 4,530,233	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,530,233	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	449,391	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 449,391	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	2,700	13
14	Non-Patient Meals	667	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	4,103	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	10,900	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 18,370	23
D. Non-Operating Revenue			
24	Contributions	10,327	24
25	Interest and Other Investment Income***	4	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,331	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	69,230	28
28a	<u>Misc. Income</u>	1,404	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 70,634	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,078,959	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	824,029	31
32	Health Care	2,477,813	32
33	General Administration	1,805,826	33
B. Capital Expense			
34	Ownership	336,527	34
C. Ancillary Expense			
35	Special Cost Centers	162,650	35
36	Provider Participation Fee	58,743	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,665,588	40
41	Income before Income Taxes (line 30 minus line 40)**	(586,629)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (586,629)	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 Geneva Care Center

0043448

Report Period Beginning: 01/01/05

Ending:

12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,784	2,071	\$ 63,537	\$ 30.68	1
2	Assistant Director of Nursing	1,351	1,417	40,139	28.33	2
3	Registered Nurses	14,429	15,531	438,374	28.23	3
4	Licensed Practical Nurses	16,523	17,645	444,389	25.18	4
5	CNAs & Orderlies	72,711	77,414	991,613	12.81	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,738	4,033	59,492	14.75	8
9	Activity Director	1,760	1,824	39,415	21.61	9
10	Activity Assistants	4,381	4,547	57,566	12.66	10
11	Social Service Workers	1,912	2,080	39,106	18.80	11
12	Dietician	1,936	2,112	42,642	20.19	12
13	Food Service Supervisor					13
14	Head Cook	8,004	8,563	93,611	10.93	14
15	Cook Helpers/Assistants	8,737	9,157	68,324	7.46	15
16	Dishwashers					16
17	Maintenance Workers	2,751	2,877	47,517	16.52	17
18	Housekeepers	8,735	9,296	71,594	7.70	18
19	Laundry	2,286	2,488	30,347	12.20	19
20	Administrator	1,952	2,080	73,030	35.11	20
21	Assistant Administrator					21
22	Other Administrative	1,968	2,080	49,523	23.81	22
23	Office Manager					23
24	Clerical	5,618	6,282	90,752	14.45	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>	952	1,055	18,722	17.75	33
34	TOTAL (lines 1 - 33)	161,528	172,552	\$ 2,759,693 *	\$ 15.99	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	208	\$ 10,808	1,3	35
36	Medical Director	\$300/mth	3,600	9,3	36
37	Medical Records Consultant	28	1,617	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	93	4,534	11,3	44
45	Social Service Consultant	10	550	12,3	45
46	Other(specify)				46
47	<u>Podiatrist</u>	18	2,625	9,3	47
48					48
49	TOTAL (lines 35 - 48)	357	\$ 23,734		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 5048 - Life Service Network
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Yes If YES, what is the capacity? 107
- (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. \$ 30,314 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. \$ 58,743
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. \$ 667
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not issued yet
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.