

		FOR BHF USE					

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

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

I. IDPH License ID Number: 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

HFS 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 01/01/2007 to 12/31/2007 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: 01/01/2007 Ending: 12/31/2007

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>73</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>39,055</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>279</u>	<u>5,369</u>	<u>5,648</u>	8
9	SNF/PED					9
10	ICF	<u>23,688</u>	<u>6,206</u>		<u>29,894</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>23,688</u>	<u>6,485</u>	<u>5,369</u>	<u>35,542</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.00%

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 34 and days of care provided 5,369

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

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

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	229,146	29,800	18,414	277,360		277,360	277,360			1
2	Food Purchase		230,765		230,765		230,765	2,309	233,074		2
3	Housekeeping	78,393	12,880	155	91,428		91,428		91,428		3
4	Laundry	25,294	6,566	92,084	123,944		123,944		123,944		4
5	Heat and Other Utilities			101,961	101,961		101,961	1,630	103,591		5
6	Maintenance	58,360	7,683	68,684	134,727		134,727	18,215	152,942		6
7	Other (specify):* Pastoral Care	43,028	579	7,355	50,962		50,962	6,809	57,771		7
8	TOTAL General Services	434,221	288,273	288,653	1,011,147		1,011,147	28,963	1,040,110		8
	B. Health Care and Programs										
9	Medical Director			18,638	18,638		18,638		18,638		9
10	Nursing and Medical Records	2,353,873	143,997	96,116	2,593,986		2,593,986		2,593,986		10
10a	Therapy			398,827	398,827		398,827		398,827		10a
11	Activities	110,146	5,096	11,741	126,983		126,983	509	127,492		11
12	Social Services	33,758	1,261	1,059	36,078		36,078		36,078		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,497,777	150,354	526,381	3,174,512		3,174,512	509	3,175,021		16
	C. General Administration										
17	Administrative	264,125	23,808	761,520	1,049,453		1,049,453	(237,726)	811,727		17
18	Directors Fees										18
19	Professional Services			16,990	16,990		16,990	136,293	153,283		19
20	Dues, Fees, Subscriptions & Promotions			30,438	30,438		30,438	(9,916)	20,522		20
21	Clerical & General Office Expenses			38,500	38,500		38,500	8,862	47,362		21
22	Employee Benefits & Payroll Taxes			727,142	727,142		727,142	86,557	813,699		22
23	Inservice Training & Education			14,584	14,584		14,584	4,229	18,813		23
24	Travel and Seminar			13,213	13,213		13,213	6,040	19,253		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,240	93,240		93,240	1,115	94,355		26
27	Other (specify):* Bad Debt			24,112	24,112		24,112	(24,112)			27
28	TOTAL General Administration	264,125	23,808	1,719,739	2,007,672		2,007,672	(28,658)	1,979,014		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,196,123	462,435	2,534,773	6,193,331		6,193,331	814	6,194,145		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: 01/01/2007 Ending: 12/31/2007

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			365,122	365,122		365,122	97,885	463,007			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							174,915	174,915			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							14,495	14,495			34
35	Rent-Equipment & Vehicles			12,306	12,306		12,306	1,972	14,278			35
36	Other (specify):*											36
37	TOTAL Ownership			377,428	377,428		377,428	289,267	666,695			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			327,038	327,038		327,038	(171,679)	155,359			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,422	58,422		58,422		58,422			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			385,460	385,460		385,460	(171,679)	213,781			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,196,123	462,435	3,297,661	6,956,219		6,956,219	118,402	7,074,621			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:

01/01/2007

Ending:

12/31/2007

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	(1,248)	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	12,289	30		9
10	Interest and Other Investment Income	(3,106)	32		10
11	Discounts, Allowances, Rebates & Refunds	(171,679)	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	(24,112)	27		24
25	Fund Raising, Advertising and Promotional	(18,021)	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)	\$ (205,877)		\$	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)	317,470		34
35	Other- Attach Schedule	(6,809)		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 310,661		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 104,784		37

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

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

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

BHF USE ONLY					
48		49		50	
				51	
					52

Provena Geneva Care Center

ID# 0043448

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Development Misc	\$ 6,809	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	6,809		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/2007

Ending:

12/31/2007

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	(1,248)	3,557	0	0	0	0	0	0	0	0	0	2,309	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	1,630	0	0	0	0	0	0	0	0	0	1,630	5
6	Maintenance	0	429	17,786	0	0	0	0	0	0	0	0	18,215	6
7	Other (specify):*	6,809	0	0	0	0	0	0	0	0	0	0	6,809	7
8	TOTAL General Services	5,561	5,616	17,786	0	28,963	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	509	0	0	0	0	0	0	0	0	0	509	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	509	0	0	0	0	0	0	0	0	0	509	16
	C. General Administration													
17	Administrative	0	(348,810)	111,084	0	0	0	0	0	0	0	0	(237,726)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	58,746	77,547	0	0	0	0	0	0	0	0	136,293	19
20	Fees, Subscriptions & Promotions	(18,021)	8,105	0	0	0	0	0	0	0	0	0	(9,916)	20
21	Clerical & General Office Expenses	0	8,862	0	0	0	0	0	0	0	0	0	8,862	21
22	Employee Benefits & Payroll Taxes	0	47,179	39,378	0	0	0	0	0	0	0	0	86,557	22
23	Inservice Training & Education	0	4,229	0	0	0	0	0	0	0	0	0	4,229	23
24	Travel and Seminar	0	6,040	0	0	0	0	0	0	0	0	0	6,040	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	1,115	0	0	0	0	0	0	0	0	0	1,115	26
27	Other (specify):*	(24,112)	0	0	0	0	0	0	0	0	0	0	(24,112)	27
28	TOTAL General Administration	(42,133)	(214,534)	228,009	0	(28,658)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(36,572)	(208,409)	245,795	0	814	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/2007 Ending:

12/31/2007

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	12,289	0	85,596	0	0	0	0	0	0	0	0	97,885	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,106)	0	178,021	0	0	0	0	0	0	0	0	174,915	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	14,495	0	0	0	0	0	0	0	0	14,495	34
35	Rent-Equipment & Vehicles	0	0	1,972	0	0	0	0	0	0	0	0	1,972	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	9,183	0	280,084	0	289,267	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	(171,679)	0	0	0	0	0	0	0	0	0	0	(171,679)	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	(171,679)	0	0	0	0	0	0	0	0	0	0	(171,679)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(199,068)	(208,409)	525,879	0	118,402	45							

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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%	\$ 3,557	\$ 3,557	1
2	V	5 Utilities		Provena Senior Services	100.00%	1,630	1,630	2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	429	429	3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	509	509	4
5	V	17 Admin - Misc. Other	534,000	Provena Senior Services	100.00%	10,650	(523,350)	5
6	V	17 Administrative Services		Provena Senior Services	100.00%	174,540	174,540	6
7	V	19 Professional Salaries		Provena Senior Services	100.00%	58,746	58,746	7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	8,105	8,105	8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	8,862	8,862	9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	47,179	47,179	10
11	V	23 Education/Conference		Provena Senior Services	100.00%	4,229	4,229	11
12	V	24 Travel		Provena Senior Services	100.00%	6,040	6,040	12
13	V	26 Insurance		Provena Senior Services	100.00%	1,115	1,115	13
14	Total		\$ 534,000			\$ 325,591	\$ * (208,409)	14

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

Facility Name & ID Number Provena Geneva Care Center# 0043448Report Period Beginning: 01/01/2007 Ending: 12/31/2007

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%	\$ 3,147	\$ 3,147	15
16	V	32 Interest		Provena Senior Services	100.00%	178,021	178,021	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	14,495	14,495	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	1,972	1,972	18
19	V	17 Admin Salaries	93,960	Provena Health Services	100.00%	75,452	(18,508)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	17,760	17,760	20
21	V	30 Depreciation		Provena Health Services	100.00%	82,449	82,449	21
22	V	19 Admin Consulting,Other		Provena Health Services	100.00%	77,547	77,547	22
23	V	17 Information Systems Salaries	133,560	Provena Health Services	100.00%	25,700	(107,860)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	5,893	5,893	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	170,645	170,645	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	35,910	35,910	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	8,452	8,452	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	30,897	30,897	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	7,273	7,273	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	17,786	17,786	30
31	V	39 Ancillary Services - Other	327,038	Provena Senior Services Pharmacy	100.00%	327,038		31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 554,558			\$ 1,080,437	\$ * 525,879	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:

01/01/2007

Ending:

12/31/2007

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: 01/01/2007

Ending: 2/31/2007

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 6,620,619	19	\$ 44,100	\$	534,000	\$ 3,557	1
2	5	Utilities	Management Fee Income 6,620,619	19	20,208		534,000	1,630	2
3	6	Maintenance - Other	Management Fee Income 6,620,619	19	5,313		534,000	429	3
4	11	Activities-Special Events	Management Fee Income 6,620,619	19	6,306		534,000	509	4
5	17	Admin - Misc. Other	Management Fee Income 6,620,619	19	132,045		534,000	10,650	5
6	17	Administrative Salaries	Management Fee Income 6,620,619	19	2,163,976	2,163,976	534,000	174,540	6
7	19	Professional Services	Management Fee Income 6,620,619	19	728,345		534,000	58,746	7
8	20	Dues,Subscriptions	Management Fee Income 6,620,619	19	100,486		534,000	8,105	8
9	21	Clerical Supplies	Management Fee Income 6,620,619	19	109,877		534,000	8,862	9
10	22	Employee Benefits	Management Fee Income 6,620,619	19	584,930		534,000	47,179	10
11	23	Education/Conference	Management Fee Income 6,620,619	19	52,430		534,000	4,229	11
12	24	Travel	Management Fee Income 6,620,619	19	74,891		534,000	6,040	12
13	26	Insurance	Management Fee Income 6,620,619	19	13,824		534,000	1,115	13
14	30	Depreciation	Management Fee Income 6,620,619	19	39,013		534,000	3,147	14
15	32	Interest	Management Fee Income 6,620,619	19	2,207,136		534,000	178,021	15
16	34	Rent - Facility	Management Fee Income 6,620,619	19	179,713		534,000	14,495	16
17	35	Rent - Equipment	Management Fee Income 6,620,619	19	24,448		534,000	1,972	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 6,487,041	\$ 2,163,976		\$ 523,226	25

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,239,804	10	\$ 995,585	\$ 995,585	93,960	\$ 75,452	1
2	22	Employee Benefits	Operating Expense	1,239,804	10	234,337		93,960	17,760	2
3	30	Depreciation	Operating Expense	1,239,804	10	1,087,913		93,960	82,449	3
4	19	Admin Consulting,Other	Operating Expense	1,239,804	10	1,023,231		93,960	77,547	4
5	17	Information Systems Salaries	Operating Expense	1,759,764	10	338,615	338,615	133,560	25,700	5
6	22	Information Systems Benefits	Operating Expense	1,759,764	10	77,649		133,560	5,893	6
7	17	Information Systems - Other	Operating Expense	1,759,764	10	2,248,393		133,560	170,645	7
8	17	Admin Salaries	Direct Cost	1,239,804	10	473,834	473,834	93,960	35,910	8
9	22	Employee Benefits	Direct Cost	1,239,804	10	111,529		93,960	8,452	9
10	17	Information Systems Salaries	Direct Cost	1,759,764	10	407,099	407,099	133,560	30,897	10
11	22	Information Systems Benefits	Direct Cost	1,759,764	10	95,822		133,560	7,273	11
12	6	Information Systems - Equip Main	Direct Cost	1,759,764	10	234,347		133,560	17,786	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,328,354	\$ 2,215,133		\$ 555,764	25

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning: 01/01/2007

Ending: 2/31/2007

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		\$	\$		\$ 327,038	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				\$	\$		\$ 327,038	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	Home Office Allocation									\$ 178,021	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 178,021	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 178,021	15									

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

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2006 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2006 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2006.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2006 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2007 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2006 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena 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 2006 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2006.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
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 2006 tax bills which were listed in Section A to this statement. Be sure to use the 2006 tax bill which is normally paid during 2007.

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

Facility Name & ID Number Provena Geneva Care Center

0043448 Report Period Beginning:

01/01/2007 Ending:

12/31/2007

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,000 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 2

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

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

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Nursing Home</u>			\$ <u>750,000</u>	1
2					2
3	TOTALS			\$ 750,000	3

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	107		1998		\$ 5,000,000	\$ 166,667	30	\$ 166,667		\$ 1,583,333	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1999		20,948	1,920	9	1,920		19,003	9
10	Various		2000		5,712	571	10	571		4,284	10
11	Various		2001		638,937	25,658	15	25,658		168,323	11
12	Various		2002		8,118	1,054	11	1,054		6,408	12
13	Various		2003		74,217	6,831	10	6,831		30,738	13
14											14
15	NEW PHONE SYSTEM		2004		19,567	1,957	10	1,957		6,143	15
16	REPLACEMENT OF BATHTUBS		2004		11,463	1,146	10	1,146		4,012	16
17	NEW SHOWERS		2004		9,000	900	10	900		3,150	17
18	LANDSCAPING		2004		7,077	708	10	708		2,477	18
19	CUPOLA AND CURB FLASHING		2004		6,890	689	10	689		2,412	19
20	ELEVATOR REPAIRS		2004		5,990	300	20	300		1,048	20
21	2ND FLOOR NURSES STATION		2004		5,280	264	20	264		924	21
22	CUSTOM INSIGNIA		2004		3,845	385	10	385		1,346	22
23	ROOF REPAIR FOR LEAKS		2004		2,800	280	10	280		980	23
24	SWITCH BOARD		2004		1,937	194	10	194		678	24
25	ANSUL SUPPRESSION SYSTEM		2004		1,898	190	10	190		664	25
26	HOT WATER PIPE REPAIRS		2004		1,851	370	5	370		1,296	26
27	BRASS KNOB LOCKSET		2004		1,580	158	10	158		553	27
28	LOCKSET		2004		593	59	10	59		205	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/2007 Ending: 12/31/2007

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	CARPET FOR LOBBY, CORRID	2005	\$ 32,460	\$ 6,492	5	\$ 6,492	\$	\$ 19,476	37
38	TEKNOFLOR FOR DINING ROO	2005	19,900	1,990	10	1,990		4,975	38
39	REPLACE KITCHEN ISLAND	2005	15,571	1,557	10	1,557		3,893	39
40	MASONRY RESTORATION	2005	4,375	875	5	875		2,188	40
41	GREASE TRAP	2005	1,625	163	10	163		406	41
42	INSTALL 5 THERMOSTATS	2005	933	93	10	93		233	42
43	REPLACEMENT OF DUCT WORK	2005	745	149	5	149		447	43
44	PERSONALIZED BRICKS FOR	2005	675	68	10	68		203	44
45									45
46	NEW FLOORING FOR PRAYER	2006	21,165	4,233	5	4,233		6,350	46
47	NEW ELECTRICAL PANELS	2006	14,375	958	15	958		1,438	47
48	ROOF REPAIRS ON 100, 200, &	2006	4,800	480	10	480		720	48
49	ELECTRIC FIRE REPAIR	2006	2,378	238	10	238		476	49
50	AIR HANDLER	2006	2,205	221	10	221		331	50
51									51
52	RESURFACE/OVERLAY/REPAIR	2007	50,590	3,162	8	6,324	3,162	3,162	52
53	25 TRANE COOLING UNITS	2007	44,862	1,495	15	2,991	1,495	1,495	53
54	FRONT ENTRY REMODEL	2007	43,575	2,179	10	4,358	2,179	2,179	54
55	MEETING ROOM REMODEL	2007	20,058	669	15	1,337	669	669	55
56	ROOFING REPAIRS	2007	7,585	759	10	1,517	759	759	56
57	CONVERSION OF ICF TO SNF	2007	2,979	99	15	199	99	99	57
58	PHONE SYSTEM PORT INSTAL	2007	1,712	86	10	171	86	86	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)		\$ 6,120,270	\$ 236,264		\$ 244,712	\$ 8,448	\$ 1,887,559	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: 01/01/2007 Ending: 12/31/2007

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	\$ 1,288,184	\$ 125,017	\$ 125,017	\$	10	\$ 892,044	71
72	Current Year Purchases	70,180	3,841	7,682	3,841	11	3,841	72
73	Fully Depreciated Assets	77,808				5	77,886	73
74	Home Office Allocation		85,596	85,596				74
75	TOTALS	\$ 1,436,172	\$ 214,454	\$ 218,295	\$ 3,841		\$ 973,771	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)	\$ 8,306,442	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 450,718	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 463,007	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 12,289	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,861,330	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.

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning: 01/01/2007

Ending: 12/31/2007

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ _____			3
4	Additions				_____			4
5	Home Office Allocation				14,495			5
6					_____			6
7	TOTAL				\$ 14,495			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.	_____ /2008	\$ _____
13.	_____ /2009	\$ _____
14.	_____ /2010	\$ _____

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: \$ 71,122 Description: Nursing \$53063, Activities \$504, Dietary \$1590, Plant Eng. \$295, Laundry \$1392, Admin \$12306, Home Office
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$ _____	\$ _____	17
18			_____	_____	18
19			_____	_____	19
20			_____	_____	20
21	TOTAL		\$ _____	\$ _____	21

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

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

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</p> <p style="text-align: right;"> <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:

01/01/2007 Ending:

12/31/2007

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a, 3	hrs	\$	2,920	\$ 157,658	\$	2,920	\$ 157,658	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		643	34,697		643	34,697	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		3,824	206,472		3,824	206,472	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39, 3	# of prescrpts				327,038		327,038	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	7,386	\$ 398,827	\$ 327,038	7,386	\$ 725,865	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: 01/01/2007

Ending:

12/31/2007**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 12/31/2007

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,785,520	\$	1
2	Cash-Patient Deposits	113,303		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	11,176,143		3
4	Supply Inventory (priced at)	533,002		4
5	Short-Term Investments			5
6	Prepaid Insurance	16,312		6
7	Other Prepaid Expenses	134,911		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 20,759,191	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,331,517		12
13	Land	6,751,685		13
14	Buildings, at Historical Cost	83,408,867		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,112,162		16
17	Accumulated Depreciation (book methods)	(49,944,144)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	120,120		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 65,780,207	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 86,539,398	\$	25

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,502,583	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(2,361,850)	3
4	Adj. To reconcile consolidated equity & consolidated income	2,891,435	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 74,032,168	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(661,740)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock	(333,474)	9
10	Stock Options Exercised		10
11	Contributions and Grants	417,345	11
12	Expenditures for Specific Purposes	(200,543)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (778,412)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 73,253,756	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Geneva Care Center# 0043448Report Period Beginning: 01/01/2007Ending: 12/31/2007**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	\$ 4,949,380	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,949,380	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	790,899	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 790,899	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	1,630	13
14	Non-Patient Meals	1,248	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	295,779	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	46,560	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 345,217	23
D. Non-Operating Revenue			
24	Contributions	31,789	24
25	Interest and Other Investment Income***	3,106	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 34,895	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Purchase Rebates</u>	171,679	28
28a	<u>Misc. Income</u>	2,686	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 174,365	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,294,756	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,011,147	31
32	Health Care	3,174,512	32
33	General Administration	2,007,672	33
B. Capital Expense			
34	Ownership	377,428	34
C. Ancillary Expense			
35	Special Cost Centers	327,038	35
36	Provider Participation Fee	58,422	36
D. Other Expenses (specify):			
37	<u>Loss on SOFA</u>	277	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,956,496	40
41	Income before Income Taxes (line 30 minus line 40)**	(661,740)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (661,740)	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: 01/01/2007

Ending:

12/31/2007

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	1,928	2,080	\$ 77,894	\$ 37.45	1
2	Assistant Director of Nursing	1,888	2,080	67,064	32.24	2
3	Registered Nurses	19,251	20,671	708,438	34.27	3
4	Licensed Practical Nurses	9,068	9,610	305,236	31.76	4
5	CNAs & Orderlies	77,789	82,275	1,160,206	14.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,830	4,223	35,035	8.30	8
9	Activity Director	1,824	2,069	37,190	17.97	9
10	Activity Assistants	6,660	7,031	72,956	10.38	10
11	Social Service Workers	1,872	2,030	33,758	16.63	11
12	Dietician	1,928	2,160	51,832	24.00	12
13	Food Service Supervisor					13
14	Head Cook	7,350	8,192	86,363	10.54	14
15	Cook Helpers/Assistants	9,525	10,385	90,951	8.76	15
16	Dishwashers					16
17	Maintenance Workers	3,183	3,368	58,360	17.33	17
18	Housekeepers	7,719	8,617	78,393	9.10	18
19	Laundry	2,960	3,146	25,294	8.04	19
20	Administrator	1,792	2,138	74,906	35.04	20
21	Assistant Administrator					21
22	Other Administrative	3,696	4,160	77,851	18.71	22
23	Office Manager	1,896	2,080	44,202	21.25	23
24	Clerical	6,828	7,442	67,166	9.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral Care</u>	1,920	2,080	43,028	20.69	33
34	TOTAL (lines 1 - 33)	172,907	185,837	\$ 3,196,123 *	\$ 17.20	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	151	\$ 12,323	1,3	35
36	Medical Director	\$800/mo	9,600	9,3	36
37	Medical Records Consultant	12	690	10,3	37
38	Nurse Consultant	60	9,038	9,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	2,920	11,3	44
45	Social Service Consultant	18	1,059	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	301	\$ 35,630		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

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning: 01/01/2007

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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	
Steve Harris	Administrator	0	\$ 53,543	Workers' Compensation Insurance	\$ 89,400	IDPH License Fee	\$	
Administrative Staff	Human Resources	0	35,392	Unemployment Compensation Insurance	15,273	Advertising: Employee Recruitment		
Administrative Staff	Bookkeeper	0	15,388	FICA Taxes	237,223	Health Care Worker Background Check		
Administrative Staff	Receptionist	0	30,179	Employee Health Insurance	235,628	(Indicate # of checks performed <u>50</u>)		
Administrative Staff	Admin Asst	0	30,679	Employee Meals		Patient Background Checks	<u>109</u>	
Administrative Staff	Admissions	0	77,581	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	4,600	
Dawn Renee Furman	Administrator	0	21,363	Life Insurance	14,710	Dues & Subscriptions	7,010	
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	117,356	Advertising & Public Relations	18,828	
(List each licensed administrator separately.)			\$ 264,125	Employee Benefits	7,115			
B. Administrative - Other				Employment Screening	7,133	Home Office Allocation	8,105	
Description			Amount	Employment Recognition	3,304	Less: Public Relations Expense	()	
Corporate Service Fee			\$ 93,960	Home Office Allocation	86,557	Non-allowable advertising	(18,021)	
Corporate IS Fee			133,560			Yellow page advertising	()	
Mgmt Fee			338,160	TOTAL (agree to Schedule V, line 22, col.8)			\$ 813,699	
Mgmt Fee Interest			195,840	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 761,520	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		\$ 772	Out-of-State Travel			\$	
Survey & Analytical Tools	Various		8,092					
Shredding/Companion Radio	Various		3,675	In-State Travel			13,213	
Background Check	Various		3,828					
Culligan	Various		494	Seminar Expense				
Outsourced Services	Various		129	Home Office Allocation			6,040	
				Entertainment Expense			()	
				(agree to Sch. V, line 24, col. 8)				
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$ 19,253	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 16,990					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena Geneva Care Center

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 \$4,247
- (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. \$ 65,612 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. \$ 58,422
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. \$ 1,248
- (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.