

Facility Name & ID Number Provena Geneva Care Center# 0043448 Report Period Beginning: 01/01/08 Ending: 12/31/08

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 4/30/08

	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>63</u>	<u>19,549</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>73</u>	Intermediate (ICF)	<u>44</u>	<u>19,613</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>39,162</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>6,390</u>	<u>1,411</u>	<u>7,313</u>	<u>15,114</u>	8
9	SNF/PED					9
10	ICF	<u>14,910</u>	<u>3,295</u>		<u>18,205</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,300</u>	<u>4,706</u>	<u>7,313</u>	<u>33,319</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.08%

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 - NoneF. Does the facility maintain a daily midnight census? Yes

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

YES NO

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

YES NO

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

Date started 03/01/1998

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

YES Date 03/01/98 NO

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

YES NO If YES, enter number of beds certified 63 and days of care provided 7,313Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH* Is your fiscal year identical to your tax year? YES NO Tax Year: 12/31/08 Fiscal Year: 12/31/08

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	234,440	28,032	46,413	308,885		308,885		308,885		1
2	Food Purchase		187,094		187,094		187,094	936	188,030		2
3	Housekeeping	89,713	13,265	12	102,990		102,990		102,990		3
4	Laundry	29,106	3,354	92,303	124,763		124,763		124,763		4
5	Heat and Other Utilities			123,923	123,923		123,923	2,967	126,890		5
6	Maintenance	59,005	9,301	99,272	167,578		167,578	27,404	194,982		6
7	Other (specify):*	45,119	1,417	9,724	56,260		56,260	8,773	65,033		7
8	TOTAL General Services	457,383	242,463	371,647	1,071,493		1,071,493	40,080	1,111,573		8
	B. Health Care and Programs										
9	Medical Director			13,738	13,738		13,738		13,738		9
10	Nursing and Medical Records	2,627,726	180,124	107,128	2,914,978		2,914,978		2,914,978		10
10a	Therapy			730,830	730,830		730,830		730,830		10a
11	Activities	128,817	4,850	10,786	144,453		144,453	597	145,050		11
12	Social Services	20,249		1,073	21,322		21,322		21,322		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,776,792	184,974	863,555	3,825,321		3,825,321	597	3,825,918		16
	C. General Administration										
17	Administrative	287,184	29,006	792,240	1,108,430		1,108,430	(356,170)	752,260		17
18	Directors Fees										18
19	Professional Services			15,518	15,518		15,518	45,631	61,149		19
20	Dues, Fees, Subscriptions & Promotions			40,080	40,080		40,080	(11,341)	28,739		20
21	Clerical & General Office Expenses			30,452	30,452		30,452	8,675	39,127		21
22	Employee Benefits & Payroll Taxes			785,896	785,896		785,896	194,964	980,860		22
23	Inservice Training & Education			8,286	8,286		8,286	3,180	11,466		23
24	Travel and Seminar			11,721	11,721		11,721	6,503	18,224		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			77,616	77,616		77,616	452	78,068		26
27	Other (specify):* Bad Debt			19,182	19,182		19,182	(19,182)			27
28	TOTAL General Administration	287,184	29,006	1,780,991	2,097,181		2,097,181	(127,288)	1,969,893		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,521,359	456,443	3,016,193	6,993,995		6,993,995	(86,611)	6,907,384		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: 01/01/08 Ending: 12/31/08

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			337,601	337,601	337,601	76,691	414,292				30
31	Amortization of Pre-Op. & Org.											31
32	Interest						629,637	629,637				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds						20,050	20,050				34
35	Rent-Equipment & Vehicles			13,981	13,981	13,981	3,029	17,010				35
36	Other (specify):*											36
37	TOTAL Ownership			351,582	351,582	351,582	729,407	1,080,989				37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			399,249	399,249	399,249	(217,510)	181,739				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			457,992	457,992	457,992	(217,510)	240,482				44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,521,359	456,443	3,825,767	7,803,569	7,803,569	425,286	8,228,855				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: 01/01/08

Ending: 12/31/08

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,996)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,558	30		9
10	Interest and Other Investment Income	(1,254)	32		10
11	Discounts, Allowances, Rebates & Refunds	(217,510)	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	(19,182)	27		24
25	Fund Raising, Advertising and Promotional	(18,785)	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)	\$ (254,169)		\$	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)	670,682		34
35	Other- Attach Schedule	8,773		35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 679,455		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 425,286		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	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: 01/01/08

Ending: 12/31/08

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/08

Ending:

12/31/08

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,996)	2,932	0	0	0	0	0	0	0	0	0	936	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	2,967	0	0	0	0	0	0	0	0	0	2,967	5
6	Maintenance	0	1,351	26,053	0	0	0	0	0	0	0	0	27,404	6
7	Other (specify):*	8,773	0	0	0	0	0	0	0	0	0	0	8,773	7
8	TOTAL General Services	6,777	7,250	26,053	0	40,080	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	597	0	0	0	0	0	0	0	0	0	597	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	597	0	0	0	0	0	0	0	0	0	597	16
	C. General Administration													
17	Administrative	0	(335,199)	(20,971)	0	0	0	0	0	0	0	0	(356,170)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	31,235	14,396	0	0	0	0	0	0	0	0	45,631	19
20	Fees, Subscriptions & Promotions	(18,785)	7,444	0	0	0	0	0	0	0	0	0	(11,341)	20
21	Clerical & General Office Expenses	0	8,675	0	0	0	0	0	0	0	0	0	8,675	21
22	Employee Benefits & Payroll Taxes	0	55,606	139,358	0	0	0	0	0	0	0	0	194,964	22
23	Inservice Training & Education	0	3,180	0	0	0	0	0	0	0	0	0	3,180	23
24	Travel and Seminar	0	6,503	0	0	0	0	0	0	0	0	0	6,503	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	452	0	0	0	0	0	0	0	0	0	452	26
27	Other (specify):*	(19,182)	0	0	0	0	0	0	0	0	0	0	(19,182)	27
28	TOTAL General Administration	(37,967)	(222,104)	132,783	0	(127,288)	28							
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(31,190)	(214,257)	158,836	0	(86,611)	29							

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/08 Ending:

12/31/08

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	4,558	0	72,133	0	0	0	0	0	0	0	0	76,691	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,254)	0	630,891	0	0	0	0	0	0	0	0	629,637	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	20,050	0	0	0	0	0	0	0	0	20,050	34
35	Rent-Equipment & Vehicles	0	0	3,029	0	0	0	0	0	0	0	0	3,029	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,304	0	726,103	0	729,407	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	(217,510)	0	0	0	0	0	0	0	0	0	0	(217,510)	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	(217,510)	0	0	0	0	0	0	0	0	0	0	(217,510)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(245,396)	(214,257)	884,939	0	425,286	45							

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/08

Ending:

12/31/08

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	2 Food	\$	Provena Senior Services	100.00%	\$ 2,932	\$ 2,932 1
2	V	5 Utilities		Provena Senior Services	100.00%	2,967	2,967 2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	1,351	1,351 3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	597	597 4
5	V	17 Admin - Misc. Other	527,640	Provena Senior Services	100.00%	(1,603)	(529,243) 5
6	V	17 Administrative Salaries		Provena Senior Services	100.00%	194,044	194,044 6
7	V	19 Professional Services		Provena Senior Services	100.00%	31,235	31,235 7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	7,444	7,444 8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	8,675	8,675 9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	55,606	55,606 10
11	V	23 Education/Conference		Provena Senior Services	100.00%	3,180	3,180 11
12	V	24 Travel		Provena Senior Services	100.00%	6,503	6,503 12
13	V	26 Insurance		Provena Senior Services	100.00%	452	452 13
14	Total		\$ 527,640			\$ 313,383	\$ * (214,257) 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: 01/01/08Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 Depreciation	\$	Provena Senior Services	100.00%	\$ 2,930	\$ 2,930	15
16	V	32 Interest		Provena Senior Services	100.00%	254,024	254,024	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	20,050	20,050	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	3,029	3,029	18
19	V	17 Admin Salaries	103,800	Provena Health Services	100.00%	64,685	(39,115)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	49,226	49,226	20
21	V	30 Depreciation		Provena Health Services	100.00%	69,203	69,203	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	14,396	14,396	22
23	V	17 Information Systems Salaries	160,800	Provena Health Services	100.00%	112,289	(48,511)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	29,829	29,829	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	15,212	15,212	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	20,869	20,869	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	32,883	32,883	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	30,574	30,574	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	27,420	27,420	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	26,053	26,053	30
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	376,867	376,867	31
32	V	39 Ancillary Services - Other	399,249	Provena Senior Services Pharmacy	100.00%	399,249		32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 663,849			\$ 1,548,788	\$ * 884,939	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: 01/01/08 Ending: 12/31/08

VII. RELATED PARTIES (continued)

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

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

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

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

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

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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 6,616,778	19	\$ 36,766	\$	527,640	\$ 2,932	1
2	5	Utilities	Management Fee Income 6,616,778	19	37,212		527,640	2,967	2
3	6	Maintenance - Other	Management Fee Income 6,616,778	19	16,939		527,640	1,351	3
4	11	Activities-Special Events	Management Fee Income 6,616,778	19	7,482		527,640	597	4
5	17	Admin - Misc. Other	Management Fee Income 6,616,778	19	(20,102)		527,640	(1,603)	5
6	17	Administrative Salaries	Management Fee Income 6,616,778	19	2,433,377	2,433,377	527,640	194,044	6
7	19	Professional Services	Management Fee Income 6,616,778	19	391,693		527,640	31,235	7
8	20	Dues,Subscriptions	Management Fee Income 6,616,778	19	93,352		527,640	7,444	8
9	21	Clerical Supplies	Management Fee Income 6,616,778	19	108,789		527,640	8,675	9
10	22	Employee Benefits	Management Fee Income 6,616,778	19	697,316		527,640	55,606	10
11	23	Education/Conference	Management Fee Income 6,616,778	19	39,879		527,640	3,180	11
12	24	Travel	Management Fee Income 6,616,778	19	81,549		527,640	6,503	12
13	26	Insurance	Management Fee Income 6,616,778	19	5,664		527,640	452	13
14	30	Depreciation	Management Fee Income 6,616,778	19	36,741		527,640	2,930	14
15	32	Interest	Management Fee Income 6,616,778	19	3,185,539		527,640	254,024	15
16	34	Rent - Facility	Management Fee Income 6,616,778	19	251,434		527,640	20,050	16
17	35	Rent - Equipment	Management Fee Income 6,616,778	19	37,982		527,640	3,029	17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 7,441,612	\$ 2,433,377		\$ 593,416	25

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	17	Admin Salaries	Operating Expense	1,391,394	9	\$ 867,070	\$ 867,070	103,800	\$ 64,685	1
2	22	Employee Benefits	Operating Expense	1,391,394	9	659,854		103,800	49,226	2
3	30	Depreciation	Operating Expense	1,391,394	9	927,633		103,800	69,203	3
4	34	Rent Facility	Operating Expense	1,391,394	9	192,975		103,800	14,396	4
5	19	Admin Consulting,Other	Operating Expense	1,391,394	9	1,505,183		103,800	112,289	5
6	17	Information Systems Salaries	Operating Expense	2,155,920	9	399,935	399,935	160,800	29,829	6
7	22	Information Systems Benefits	Operating Expense	2,155,920	9	203,956		160,800	15,212	7
8	17	Information Systems - Other	Operating Expense	2,155,920	9	279,796		160,800	20,869	8
9	17	Admin Salaries	Direct Cost	1,391,394	9	440,776	440,776	103,800	32,883	9
10	17	Information Systems Salaries	Direct Cost	2,155,920	9	409,925	409,925	160,800	30,574	10
11	6	Information Systems - Equip Main	Direct Cost	2,155,920	9	367,627		160,800	27,420	11
12	19	Admin Consulting,Other	Direct Cost	1,391,394	9	349,224		103,800	26,053	12
13	32	Admin - Interest Expense	Direct Cost	1,391,394	9	5,051,741		103,800	376,867	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 11,655,695	\$ 2,117,706		\$ 869,506	25

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning: 01/01/08

Ending: 12/31/08

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation		\$	\$		\$ 399,249	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				\$	\$		\$ 399,249	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									\$ 254,024	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 254,024	9									
B. Non-Facility Related*																				
10											10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$	14									
15	TOTALS (line 9+line14)					\$	\$			\$ 254,024	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:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2007 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Provena 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 2007 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

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

Facility Name & ID Number Provena Geneva Care Center

0043448 Report Period Beginning:

01/01/08 Ending:

12/31/08

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>750,000</u>	1
2					2
3	TOTALS			\$ 750,000	3

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning:

01/01/08

Ending:

12/31/08

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	107		1998		\$ 5,000,000	\$ 166,667	30	\$ 166,667	\$	\$ 1,750,000	4
5											5
6											6
7											7
8											8
Improvement Type**											
9	Various		1999		20,948	1,920	8	1,920		20,923	9
10	Various		2000		5,712	571	10	571		4,856	10
11	Various		2001		638,937	24,812	15	24,812		193,981	11
12	Various		2002		1,368	450	15	450		403	12
13	Various		2003		74,217	6,516	10	6,516		37,254	13
14	Various		2004		79,771	7,599	11	7,599		33,487	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

*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:

01/01/08

Ending:

12/31/08

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	\$	\$ 25,968	37
38	TEKNOFLOR FOR DINING ROO	2005	19,900	1,990	10	1,990		6,965	38
39	REPLACE KITCHEN ISLAND	2005	15,571	1,557	10	1,557		5,450	39
40	MASONRY RESTORATION	2005	4,375	875	5	875		569	40
41	GREASE TRAP	2005	1,625	163	10	163		327	41
42	INSTALL 5 THERMOSTATS	2005	933	93	10	93		596	42
43	REPLACEMENT OF DUCT WORK	2005	745	149	5	149		270	43
44	PERSONALIZED BRICKS FOR	2005	675	68	10	68		3,063	44
45									45
46	NEW FLOORING FOR PRAYER	2006	21,165	4,233	5	4,233		10,583	46
47	NEW ELECTRICAL PANELS	2006	14,375	958	15	958		2,396	47
48	ROOF REPAIRS ON 100, 200, &	2006	4,800	480	10	480		1,200	48
49	ELECTRIC FIRE REPAIR	2006	2,378	238	10	238		713	49
50	AIR HANDLER	2006	2,205	221	10	221		551	50
51									51
52	PARKING LOT SEALCOAT,RESURFACE,OVERLAY,REPAIR	2007	50,590	6,324	8	6,324		9,486	52
53	25 TRANE COOLING UNITS	2007	44,862	2,991	15	2,991		4,486	53
54	2 NEW AUTO SLIDING DOORS IN ENTRY WAY	2007	46,575	4,658	10	4,658		6,836	54
55	CONSTRUCTION,ELECTRIC,WINDOWS TO OPEN DOORWA	2007	20,058	1,337	15	1,337		2,006	55
56	ROOFING REPAIRS	2007	7,585	759	10	759		1,517	56
57	CONVERSION OF ICF TO SNF	2007	3,280	219	15	219		318	57
58	PHONE SYSTEM PORT INSTAL	2007	1,712	171	10	171		257	58
59									59
60	CINEMA SYSTEM	2008	11,150	796	7	1,593	796	796	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)		\$ 6,127,972	\$ 243,305		\$ 244,101	\$ 796	\$ 2,125,254	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: 01/01/08 Ending: 12/31/08

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,333,696	\$ 90,534	\$ 90,534	\$	10	\$ 961,095	71
72	Current Year Purchases	94,122	3,762	7,524	3,762	9	3,762	72
73	Fully Depreciated Assets	103,132				5	103,210	73
74	Home Office Allocation		72,133	72,133				74
75	TOTALS	\$ 1,530,950	\$ 166,429	\$ 170,191	\$ 3,762		\$ 1,068,067	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)	\$ 8,408,922	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 409,734	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 414,292	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,558	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,193,321	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: _____

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				20,050			5
6					_____			6
7	TOTAL				\$ 20,050			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.	_____ /2009	\$ _____
13.	_____ /2010	\$ _____
14.	_____ /2011	\$ _____

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: \$ 72,597 Description: Nurse \$51,960; Activ \$487; Diet \$1,522; Plant \$238; Ldry \$1,392; Admin \$13,969; Home Off \$3,029

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/08 Ending: 12/31/08

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

01/01/08

Ending:

12/31/08

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	4,696	\$ 290,889	\$	4,696	\$ 290,889	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,390	86,991		1,390	86,991	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		5,728	352,950		5,728	352,950	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				399,249		399,249	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$	11,814	\$ 730,830	\$ 399,249	11,814	\$ 1,130,079	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: 01/01/08

Ending:

12/31/08

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/08

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 7,556,064	\$	1
2	Cash-Patient Deposits	112,800		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	14,518,279		3
4	Supply Inventory (priced at)	609,759		4
5	Short-Term Investments			5
6	Prepaid Insurance	22,320		6
7	Other Prepaid Expenses	150,561		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 22,969,783	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	6,624,013		12
13	Land	6,742,855		13
14	Buildings, at Historical Cost	84,767,866		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,707,364		16
17	Accumulated Depreciation (book methods)	(52,758,206)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Goodwill</u>	113,256		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 64,197,148	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 87,166,931	\$	25

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

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 73,253,756	1
2	Restatements (describe):		2
3	Transfer to Affiliates	(358,099)	3
4	Adj. To reconcile consolidated equity & consolidated income	816,581	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 73,712,238	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(522,546)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	683,319	11
12	Expenditures for Specific Purposes	(243,906)	12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (83,133)	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)	\$ 73,629,105	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Geneva Care Center# 0043448Report Period Beginning: 01/01/08Ending: 12/31/08**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,295,196	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,295,196	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,335,919	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,335,919	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	2,240	13
14	Non-Patient Meals	1,996	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	352,494	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	44,200	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 400,930	23
D. Non-Operating Revenue			
24	Contributions	28,315	24
25	Interest and Other Investment Income***	1,254	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 29,569	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	217,510	28
28a	Misc Income & Gain/Loss SOFA	1,899	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 219,409	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,281,023	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,071,493	31
32	Health Care	3,825,321	32
33	General Administration	2,097,181	33
B. Capital Expense			
34	Ownership	351,582	34
C. Ancillary Expense			
35	Special Cost Centers	399,249	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)*	\$ 7,803,569	40
41	Income before Income Taxes (line 30 minus line 40)**	(522,546)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (522,546)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Provena Geneva Care Center

0043448

Report Period Beginning: 01/01/08

Ending:

12/31/08

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	1,692	1,943	\$ 74,031	\$ 38.10	1
2	Assistant Director of Nursing	1,709	1,761	59,848	33.99	2
3	Registered Nurses	20,970	23,067	743,457	32.23	3
4	Licensed Practical Nurses	16,909	18,004	412,831	22.93	4
5	CNAs & Orderlies	76,442	81,169	1,259,060	15.51	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,211	5,938	78,498	13.22	8
9	Activity Director	1,920	2,080	38,898	18.70	9
10	Activity Assistants	7,192	7,747	89,919	11.61	10
11	Social Service Workers	1,367	1,466	20,250	13.81	11
12	Dietician	1,792	1,999	29,556	14.79	12
13	Food Service Supervisor					13
14	Head Cook	7,798	8,381	103,811	12.39	14
15	Cook Helpers/Assistants	9,667	10,080	101,073	10.03	15
16	Dishwashers					16
17	Maintenance Workers	2,970	3,106	59,006	19.00	17
18	Housekeepers	8,195	8,760	89,714	10.24	18
19	Laundry	3,199	3,339	29,105	8.72	19
20	Administrator	1,912	2,080	89,251	42.91	20
21	Assistant Administrator					21
22	Other Administrative	7,560	8,325	148,312	17.82	22
23	Office Manager					23
24	Clerical	4,315	4,583	49,619	10.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Pastoral</u>	1,951	2,095	45,120	21.54	33
34	TOTAL (lines 1 - 33)	182,771	195,923	\$ 3,521,359 *	\$ 17.97	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	613	\$ 40,663	1,3	35
36	Medical Director	\$800/mo	9,600	9,3	36
37	Medical Records Consultant	21	2,017	10,3	37
38	Nurse Consultant	22	3,338	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	49	2,867	11,3	44
45	Social Service Consultant	18	1,073	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	723	\$ 59,558		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. Life Service Network \$5,429
- (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. \$ 57,929 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. \$ 1,996
- (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.