

		FOR BHF USE					

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**2009**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2009)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0043448</u></p> <p><b>Facility Name:</b> <u>Provena Geneva Care Center</u></p> <p><b>Address:</b> <u>1101 East State Street</u> <u>Geneva</u> <u>60134</u>  Number City Zip Code</p> <p><b>County:</b> <u>Kane</u></p> <p><b>Telephone Number:</b> <u>(630) 232-7544</u> <b>Fax #</b> <u>(630) 232-4409</u></p> <p><b>HFS ID Number:</b> <u>371127787005</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>03/01/98</u></p> <p><b>Type of Ownership:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"> <input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT  <input checked="" type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> <u>501 C3</u> </td> <td style="width:33%; border: none;"> <input type="checkbox"/> PROPRIETARY  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other </td> <td style="width:33%; border: none;"> <input type="checkbox"/> GOVERNMENTAL  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other </td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Lynda Olinski</u> <b>Telephone Number:</b> <u>(708) 478-7916</u>  <b>Email Address:</b> _____</p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <u>501 C3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other	<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/09</u> to <u>12/31/09</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%; padding: 5px;">Officer or Administrator of Provider</td> <td style="padding: 5px;">(Signed) _____ (Type or Print Name) <u>Michael R. Gordon</u> (Title) <u>CFO, VP of Finance</u></td> </tr> <tr> <td style="width:15%; padding: 5px;">Paid Preparer</td> <td style="padding: 5px;">(Signed) _____ (Print Name and Title) _____ (Firm Name &amp; Address) _____ (Telephone) ( ) _____ Fax # ( ) _____</td> </tr> </table> <p align="right"><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  201 S. Grand Avenue East  Springfield, IL 62763-0001 <span style="float: right;">Phone # (217) 782-1630</span></p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michael R. Gordon</u> (Title) <u>CFO, VP of Finance</u>	Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <u>501 C3</u>	<input type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other	<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other						
Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) <u>Michael R. Gordon</u> (Title) <u>CFO, VP of Finance</u>							
Paid Preparer	(Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) ( ) _____ Fax # ( ) _____							

Facility Name & ID Number Provena Geneva Care Center

# 0043448 Report Period Beginning: 01/01/09 Ending: 12/31/09

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	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3	44	Intermediate (ICF)	44	16,060	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	107	TOTALS	107	39,055	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	11,582	3,517	6,792	21,891	8
9	SNF/PED					9
10	ICF	8,089	2,456		10,545	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,671	5,973	6,792	32,436	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.05%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)  
N/A - None

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

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES  NO

I. On what date did you start providing long term care at this location?  
Date started 3/1/1998

J. Was the facility purchased or leased after January 1, 1978?  
YES  Date 3/1/1998 NO

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 63 and days of care provided 6,481

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/09 Fiscal Year: 12/31/09

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	237,259	31,178	37,728	306,165		306,165		306,165		1
2	Food Purchase		200,933		200,933		200,933	1,077	202,010		2
3	Housekeeping	82,502	14,516	1,290	98,308		98,308		98,308		3
4	Laundry	27,168	12,883	86,421	126,472		126,472		126,472		4
5	Heat and Other Utilities			118,794	118,794		118,794	3,083	121,877		5
6	Maintenance	58,280	12,117	68,348	138,745		138,745	44,882	183,627		6
7	Other (specify):* <b>Pastoral Care</b>	44,798	1,239	3,882	49,919		49,919	(3,482)	46,437		7
8	<b>TOTAL General Services</b>	<b>450,007</b>	<b>272,866</b>	<b>316,463</b>	<b>1,039,336</b>		<b>1,039,336</b>	<b>45,560</b>	<b>1,084,896</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			14,800	14,800		14,800		14,800		9
10	Nursing and Medical Records	2,576,591	236,211	67,226	2,880,028		2,880,028		2,880,028		10
10a	Therapy			675,315	675,315		675,315		675,315		10a
11	Activities	131,653	4,902	9,937	146,492		146,492	248	146,740		11
12	Social Services	27,614	7	2,558	30,179		30,179		30,179		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>2,735,858</b>	<b>241,120</b>	<b>769,836</b>	<b>3,746,814</b>		<b>3,746,814</b>	<b>248</b>	<b>3,747,062</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	316,474	27,227	806,867	1,150,568		1,150,568	(346,418)	804,150		17
18	Directors Fees										18
19	Professional Services			20,575	20,575		20,575	53,891	74,466		19
20	Dues, Fees, Subscriptions & Promotions			40,382	40,382		40,382	(21,740)	18,642		20
21	Clerical & General Office Expenses			28,634	28,634		28,634	7,230	35,864		21
22	Employee Benefits & Payroll Taxes			809,737	809,737		809,737	252,638	1,062,375		22
23	Inservice Training & Education			2,954	2,954		2,954	2,698	5,652		23
24	Travel and Seminar			8,461	8,461		8,461	4,755	13,216		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			93,724	93,724		93,724	(67)	93,657		26
27	Other (specify):* <b>Bad Debt</b>			(23,817)	(23,817)		(23,817)	23,817			27
28	<b>TOTAL General Administration</b>	<b>316,474</b>	<b>27,227</b>	<b>1,787,517</b>	<b>2,131,218</b>		<b>2,131,218</b>	<b>(23,196)</b>	<b>2,108,022</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>3,502,339</b>	<b>541,213</b>	<b>2,873,816</b>	<b>6,917,368</b>		<b>6,917,368</b>	<b>22,612</b>	<b>6,939,980</b>		<b>29</b>

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name &amp; ID Number

Provena Geneva Care Center

#0043448

Report Period Beginning:

01/01/09

Ending:

12/31/09

## 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	
	<b>D. Ownership</b>											
30	Depreciation			303,943	303,943		303,943	71,396	375,339			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							354,792	354,792			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							24,058	24,058			34
35	Rent-Equipment & Vehicles			18,548	18,548		18,548	2,998	21,546			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			322,491	322,491		322,491	453,244	775,735			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			432,002	432,002		432,002	(256,663)	175,339			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,583	58,583		58,583		58,583			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			490,585	490,585		490,585	(256,663)	233,922			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,502,339	541,213	3,686,892	7,730,444		7,730,444	219,193	7,949,637			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:

01/01/09

Ending:

12/31/09

**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	(1,249)	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	5,156	30		9
10	Interest and Other Investment Income	(12,011)	32		10
11	Discounts, Allowances, Rebates & Refunds	(256,663)	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	23,817	27		24
25	Fund Raising, Advertising and Promotional	(24,766)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(3,173)	20		28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (268,889)		\$	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)	491,564		34
35	Other- Attach Schedule	(3,482)		35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 488,082		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 219,193		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						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

**BHF USE ONLY**

48		49		50		51		52	
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Provena Geneva Care Center

ID# 0043448

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Development Misc	\$ (3,482)	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
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32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	<b>Total</b>	(3,482)	49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Geneva Care Center# 0043448

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,249)	2,326	0	0	0	0	0	0	0	0	0	1,077	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	3,083	0	0	0	0	0	0	0	0	0	3,083	5
6	Maintenance	0	831	44,051	0	0	0	0	0	0	0	0	44,882	6
7	Other (specify):*	(3,482)	0	0	0	0	0	0	0	0	0	0	(3,482)	7
8	<b>TOTAL General Services</b>	<b>(4,731)</b>	<b>6,240</b>	<b>44,051</b>	<b>0</b>	<b>45,560</b>	<b>8</b>							
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	248	0	0	0	0	0	0	0	0	0	248	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>248</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>248</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(329,911)	(16,507)	0	0	0	0	0	0	0	0	(346,418)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	35,098	18,793	0	0	0	0	0	0	0	0	53,891	19
20	Fees, Subscriptions & Promotions	(27,939)	6,199	0	0	0	0	0	0	0	0	0	(21,740)	20
21	Clerical & General Office Expenses	0	7,230	0	0	0	0	0	0	0	0	0	7,230	21
22	Employee Benefits & Payroll Taxes	0	96,175	156,463	0	0	0	0	0	0	0	0	252,638	22
23	Inservice Training & Education	0	2,698	0	0	0	0	0	0	0	0	0	2,698	23
24	Travel and Seminar	0	4,755	0	0	0	0	0	0	0	0	0	4,755	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	(67)	0	0	0	0	0	0	0	0	0	(67)	26
27	Other (specify):*	23,817	0	0	0	0	0	0	0	0	0	0	23,817	27
28	<b>TOTAL General Administration</b>	<b>(4,122)</b>	<b>(177,823)</b>	<b>158,749</b>	<b>0</b>	<b>(23,196)</b>	<b>28</b>							
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(8,853)</b>	<b>(171,335)</b>	<b>202,800</b>	<b>0</b>	<b>22,612</b>	<b>29</b>							

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Geneva Care Center# 0043448

Report Period Beginning:

01/01/09

Ending:

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	5,156	0	66,240	0	0	0	0	0	0	0	0	71,396	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,011)	0	366,803	0	0	0	0	0	0	0	0	354,792	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	24,058	0	0	0	0	0	0	0	0	24,058	34
35	Rent-Equipment & Vehicles	0	0	2,998	0	0	0	0	0	0	0	0	2,998	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(6,855)</b>	<b>0</b>	<b>460,099</b>	<b>0</b>	<b>453,244</b>	<b>37</b>							
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(256,663)	0	0	0	0	0	0	0	0	0	0	(256,663)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>(256,663)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(256,663)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(272,371)</b>	<b>(171,335)</b>	<b>662,899</b>	<b>0</b>	<b>219,193</b>	<b>45</b>							

**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%	\$ 2,326	\$ 2,326	1
2	V	5 Utilities		Provena Senior Services	100.00%	3,083	3,083	2
3	V	6 Maintenance - Other		Provena Senior Services	100.00%	831	831	3
4	V	11 Activities-Special Events		Provena Senior Services	100.00%	248	248	4
5	V	17 Admin - Misc. Other		Provena Senior Services	100.00%	6,371	6,371	5
6	V	17 Administrative Salaries	557,475	Provena Senior Services	100.00%	221,193	(336,282)	6
7	V	19 Professional Services		Provena Senior Services	100.00%	35,098	35,098	7
8	V	20 Dues,Subscriptions		Provena Senior Services	100.00%	6,199	6,199	8
9	V	21 Clerical Supplies		Provena Senior Services	100.00%	7,230	7,230	9
10	V	22 Employee Benefits		Provena Senior Services	100.00%	96,175	96,175	10
11	V	23 Education/Conference		Provena Senior Services	100.00%	2,698	2,698	11
12	V	24 Travel		Provena Senior Services	100.00%	4,755	4,755	12
13	V	26 Insurance		Provena Senior Services	100.00%	(67)	(67)	13
14	Total		\$ 557,475			\$ 386,140	\$ * (171,335)	14

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

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%	\$ 3,101	\$	3,101	15
16	V	32 Interest		Provena Senior Services	100.00%	188,229		188,229	16
17	V	34 Rent - Facility		Provena Senior Services	100.00%	24,058		24,058	17
18	V	35 Rent - Equipment		Provena Senior Services	100.00%	2,998		2,998	18
19	V	17 Admin Salaries	99,606	Provena Health Services	100.00%	83,465		(16,141)	19
20	V	22 Employee Benefits		Provena Health Services	100.00%	53,341		53,341	20
21	V	30 Depreciation		Provena Health Services	100.00%	63,139		63,139	21
22	V	19 Admin Consulting, Other		Provena Health Services	100.00%	18,793		18,793	22
23	V	17 Information Systems Salaries	149,786	Provena Health Services	100.00%	79,482		(70,304)	23
24	V	22 Information Systems Benefits		Provena Health Services	100.00%	29,664		29,664	24
25	V	17 Information Systems - Other		Provena Health Services	100.00%	25,487		25,487	25
26	V	17 Admin Salaries		Provena Health Services	100.00%	11,531		11,531	26
27	V	22 Employee Benefits		Provena Health Services	100.00%	47,518		47,518	27
28	V	17 Information Systems Salaries		Provena Health Services	100.00%	32,920		32,920	28
29	V	22 Information Systems Benefits		Provena Health Services	100.00%	25,940		25,940	29
30	V	6 Information Systems - Equip Maint		Provena Health Services	100.00%	44,051		44,051	30
31	V	32 Admin - Interest Expense		Provena Health Services	100.00%	178,574		178,574	31
32	V	39 Ancillary Services - Other	432,002	Provena Senior Services Pharmacy	100.00%	432,002			32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 681,394			\$ 1,344,293	\$ *	662,899	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: 01/01/09 Ending: 12/31/09

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:

01/01/09

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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	6,810,879	19	\$ 28,423	\$ 557,475	\$ 2,326	1	
2	5	Utilities	Management Fee Income	6,810,879	19	37,672	557,475	3,083	2	
3	6	Maintenance - Other	Management Fee Income	6,810,879	19	10,148	557,475	831	3	
4	11	Activities-Special Events	Management Fee Income	6,810,879	19	3,032	557,475	248	4	
5	17	Admin - Misc. Other	Management Fee Income	6,810,879	19	77,835	557,475	6,371	5	
6	17	Administrative Salaries	Management Fee Income	6,810,879	19	2,702,403	2,702,403	557,475	221,193	6
7	19	Professional Services	Management Fee Income	6,810,879	19	428,802	557,475	35,098	7	
8	20	Dues,Subscriptions	Management Fee Income	6,810,879	19	75,736	557,475	6,199	8	
9	21	Clerical Supplies	Management Fee Income	6,810,879	19	88,333	557,475	7,230	9	
10	22	Employee Benefits	Management Fee Income	6,810,879	19	1,175,007	557,475	96,175	10	
11	23	Education/Conference	Management Fee Income	6,810,879	19	32,966	557,475	2,698	11	
12	24	Travel	Management Fee Income	6,810,879	19	58,096	557,475	4,755	12	
13	26	Insurance	Management Fee Income	6,810,879	19	(818)	557,475	(67)	13	
14	30	Depreciation	Management Fee Income	6,810,879	19	37,881	557,475	3,101	14	
15	32	Interest	Management Fee Income	6,810,879	19	2,299,667	557,475	188,229	15	
16	34	Rent - Facility	Management Fee Income	6,810,879	19	293,923	557,475	24,058	16	
17	35	Rent - Equipment	Management Fee Income	6,810,879	19	36,626	557,475	2,998	17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 7,385,732	\$ 2,702,403	\$ 604,526	25	

Facility Name & ID Number Provena Geneva Care Center

# 0043448

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	1,290,832	9	\$ 1,081,653	\$ 1,081,653	99,606	\$ 83,465	1
2	22	Employee Benefits	Operating Expense	1,290,832	9	691,262		99,606	53,341	2
3	30	Depreciation	Operating Expense	1,290,832	9	818,246		99,606	63,139	3
4	34	Rent Facility	Operating Expense	1,290,832	9	243,546		99,606	18,793	4
5	19	Admin Consulting,Other	Operating Expense	1,290,832	9	1,030,040		99,606	79,482	5
6	17	Information Systems Salaries	Operating Expense	1,941,141	9	384,433	384,433	149,786	29,664	6
7	22	Information Systems Benefits	Operating Expense	1,941,141	9	330,293		149,786	25,487	7
8	17	Information Systems - Other	Operating Expense	1,941,141	9	149,433		149,786	11,531	8
9	17	Admin Salaries	Direct Cost	1,290,832	9	615,798	615,798	99,606	47,518	9
10	17	Information Systems Salaries	Direct Cost	1,941,141	9	426,627	426,627	149,786	32,920	10
11	6	Information Systems - Equip Maint	Direct Cost	1,941,141	9	336,162		149,786	25,940	11
12	19	Admin Consulting,Other	Direct Cost	1,290,832	9	570,873		99,606	44,051	12
13	32	Admin - Interest Expense	Direct Cost	1,290,832	9	2,314,209		99,606	178,574	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					\$ 8,992,575	\$ 2,508,511		\$ 693,905	25

Facility Name & ID Number Provena Geneva Care Center

# 0043448

Report Period Beginning:

01/01/09

Ending: 12/31/09

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		\$	\$		\$ 432,002	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				\$	\$		\$ 432,002	25

Facility Name & ID Number

Provena Geneva Care Center

# 0043448

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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		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
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	Home Office Allocation					\$	\$			\$ 188,229	1							
2											2							
3											3							
4											4							
5											5							
<b>Working Capital</b>																		
6											6							
7											7							
8											8							
9	<b>TOTAL Facility Related</b>					\$	\$			\$ 188,229	9							
<b>B. Non-Facility Related*</b>																		
10											10							
11											11							
12											12							
13											13							
14	<b>TOTAL Non-Facility Related</b>					\$	\$			\$	14							
15	<b>TOTALS (line 9+line14)</b>					\$	\$			\$ 188,229	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.)





Facility Name & ID Number Provena Geneva Care Center

# 0043448

Report Period Beginning:

01/01/09

Ending:

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**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).

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

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

**XI. OWNERSHIP COSTS:**

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

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	
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	107	1998		\$ 5,000,000	\$ 166,667	30	\$ 166,667	\$ 0	\$ 1,916,667
5									
6									
7									
8									
Improvement Type**									
9	Various	1999		20,948	25	8	25		20,948
10	Various	2000		5,712	571	10	571		5,427
11	Various	2001		638,937	25,658	15	25,658		219,638
12	Various	2002		1,368	22	15	22		987
13	Various	2003		74,217	6,201	10	6,201		43,455
14	Various	2004		116,028	14,360	11	14,360		75,394
15	Various	2005		42,404	4,979	10	4,979		21,051
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
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

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	NEW FLOORING FOR PRAYER	2006	\$ 21,165	\$ 4,233	5	\$ 4,233	\$	\$ 14,816	37
38	NEW ELECTRICAL PANELS	2006	14,375	958	15	958		3,354	38
39	ROOF REPAIRS ON 100, 200, &	2006	12,385	1,239	10	1,239		3,956	39
40									40
41	PARKING LOT SEALCOAT,RESURFACE,OVERLAY,REPAIR	2007	50,590	6,324	8	6,324		15,809	41
42	25 TRANE COOLING UNITS	2007	44,862	2,991	15	2,991		7,477	42
43	2 NEW AUTO SLIDING DOORS IN ENTRY WAY	2007	46,575	4,658	10	4,658		11,494	43
44	CONSTRUCTION,ELECTRIC,WINDOWS TO OPEN DOORW	2007	20,058	1,337	15	1,337		3,343	44
45	CONVERSION OF ICF TO SNF	2007	3,280	219	15	219		537	45
46	PHONE SYSTEM PORT INSTAL	2007	1,712	171	10	171		428	46
47									47
48	CINEMA SYSTEM	2008	22,305	3,186	7	3,186		3,983	48
49									49
50	STAIRWELL REPAIRS	2009	3,200	320	5	640	320	320	50
51	ELECTRIC PANEL / CIRCUIT BREAKER	2009	2,750	92	15	183	92	92	51
52	SATELITE TV	2009	1,218	87	7	174	87	87	52
53	NATURAL OAK VINYL FLOORING	2009	45,100	2,255	10	4,510	2,255	2,255	53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,189,190	\$ 246,552		\$ 249,306	\$ 2,754	\$ 2,371,516	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:

01/01/09

Ending:

12/31/09

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	\$ 640,720	\$ 54,989	\$ 54,989	\$	10	\$ 222,976	71
72	Current Year Purchases	26,642	2,402	4,804	2,402	9	2,402	72
73	Fully Depreciated Assets	861,338				5	861,338	73
74	Home Office Allocation		66,240	66,240				74
75	TOTALS	\$ 1,528,700	\$ 123,631	\$ 126,033	\$ 2,402		\$ 1,086,716	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)	\$ 8,467,890	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 370,183	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 375,339	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 5,156	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,458,232	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				24,058			5
6								6
7	TOTAL				\$ 24,058			7

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: \$ 70,898 Description: Nurse \$45,558; Activ \$171; Diet \$1,728; Plant \$95; Ldry \$1,497; Admin \$18,548; Home Off \$2,998

(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

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. \_\_\_\_\_/2010 \$ \_\_\_\_\_

13. \_\_\_\_\_/2011 \$ \_\_\_\_\_

14. \_\_\_\_\_/2012 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
							Units	Cost								
1	Licensed Occupational Therapist	10a,3	hrs	\$		3,881	\$ 247,753	\$	3,881	\$ 247,753						1
2	Licensed Speech and Language Development Therapist	10a,3	hrs			1,445	93,037		1,445	93,037						2
3	Licensed Recreational Therapist		hrs													3
4	Licensed Physical Therapist	10a,3	hrs			5,228	334,526		5,228	334,526						4
5	Physician Care		visits													5
6	Dental Care		visits													6
7	Work Related Program		hrs													7
8	Habilitation		hrs													8
9	Pharmacy	39,3	# of prescripts							433,452					433,452	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs													10
11	Academic Education		hrs													11
12	Other (specify): _____															12
13	Other (specify): _____															13
14	<b>TOTAL</b>			\$		10,554	\$ 675,316	\$	10,554	\$ 433,452			10,554	\$ 1,108,768		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: 01/01/09Ending: 12/31/09

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 12,337,938	\$	1
2	Cash-Patient Deposits	107,856		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )			3
4	Supply Inventory (priced at )	12,517,618		4
5	Short-Term Investments	682,337		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	21,512		7
8	Accounts Receivable (owners or related parties)	152,000		8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 25,819,261	\$	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,398,236		12
13	Land	6,820,469		13
14	Buildings, at Historical Cost	85,287,605		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	18,957,385		16
17	Accumulated Depreciation (book methods)	(56,011,567)		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>	106,392		23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 62,558,520	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 88,377,781	\$	25

		1 Operating	2 After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 5,373,551	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,366,224		28
29	Short-Term Notes Payable	52,481		29
30	Accrued Salaries Payable	3,681,842		30
31	Accrued Taxes Payable (excluding real estate taxes)	113,556		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,098,515		32
33	Accrued Interest Payable	17,377		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>Due to Related Party</u>	913,853		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 12,617,399	\$	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable	1,170,110		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	382,071		42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>Conditional Asset Retirement</u>	438,744		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,990,925	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 14,608,324	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 73,769,457	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 88,377,781	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>73,629,105</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Transfer to Affiliates</b>	<b>(5,368,199)</b>	<b>3</b>
<b>4</b>	<b>Adj. To reconcile consolidated equity &amp; consolidated income</b>	<b>5,133,033</b>	<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>73,393,939</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(321,909)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>857,343</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes	<b>(159,916)</b>	<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>375,518</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>73,769,457</b>	<b>24</b> *

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

Facility Name & ID Number Provena Geneva Care Center# 0043448Report Period Beginning: 01/01/09Ending: 12/31/09

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 5,438,466	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,438,466	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,263,465	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 1,263,465	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,110	13
14	Non-Patient Meals	1,249	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	378,803	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	5,558	20
21	Other Medical Services		21
22	Laundry	32,180	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 419,900	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	15,527	24
25	Interest and Other Investment Income***	12,011	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 27,538	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>Purchase Rebates</u>	256,663	28
28a	<u>Misc Income &amp; Gain/Loss SOFA</u>	2,503	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 259,166	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,408,535	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,039,336	31
32	Health Care	3,746,814	32
33	General Administration	2,131,218	33
<b>B. Capital Expense</b>			
34	Ownership	322,491	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	432,002	35
36	Provider Participation Fee	58,583	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,730,444	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(321,909)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (321,909)	43

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No 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:

**01/01/09**

Ending:

**12/31/09**

**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	1,848	2,080	\$ 85,805	\$ 41.25	1
2	Assistant Director of Nursing	1,920	2,080	70,804	34.04	2
3	Registered Nurses	18,757	20,772	614,700	29.59	3
4	Licensed Practical Nurses	20,047	22,367	592,029	26.47	4
5	CNAs & Orderlies	72,108	78,521	1,137,543	14.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,105	5,710	75,711	13.26	8
9	Activity Director	1,880	2,080	40,022	19.24	9
10	Activity Assistants	7,193	7,785	91,632	11.77	10
11	Social Service Workers	1,854	2,094	27,614	13.19	11
12	Dietician	2,156	2,308	40,801	17.68	12
13	Food Service Supervisor					13
14	Head Cook	7,372	8,068	97,344	12.07	14
15	Cook Helpers/Assistants	9,599	9,938	99,114	9.97	15
16	Dishwashers					16
17	Maintenance Workers	2,851	3,123	58,280	18.66	17
18	Housekeepers	7,593	8,309	82,501	9.93	18
19	Laundry	2,601	3,040	27,167	8.94	19
20	Administrator	1,904	2,080	125,245	60.21	20
21	Assistant Administrator					21
22	Other Administrative	7,720	8,480	129,424	15.26	22
23	Office Manager					23
24	Clerical	4,304	4,697	61,805	13.16	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>	1,883	2,083	44,798	21.51	33
34	TOTAL (lines 1 - 33)	178,695	195,615	\$ 3,502,339 *	\$ 17.90	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	314	\$ 25,504	1,3	35
36	Medical Director	\$1200/mo	14,800	9,3	36
37	Medical Records Consultant	21	1,538	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	47	2,433	11,3	44
45	Social Service Consultant	42	2,535	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	424	\$ 46,810		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

**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		
Dawn Renee Furman	Administrator	0	\$ 125,245	Workers' Compensation Insurance	\$ 97,200	IDPH License Fee	\$		
Administrative Staff	Human Resources	0	43,728	Unemployment Compensation Insurance	25,421	Advertising: Employee Recruitment			
Administrative Staff	Bookkeeper	0	32,670	FICA Taxes	255,950	Health Care Worker Background Check			
Administrative Staff	Receptionist	0	49,335	Employee Health Insurance	285,010	(Indicate # of checks performed <u>68</u> )			
Administrative Staff	Admin Asst	0	0	Employee Meals		Patient Background Checks <u>130</u>			
Administrative Staff	Admissions	0	65,496	Illinois Municipal Retirement Fund (IMRF)*		Employee Recruitment	3,970		
				Life Insurance	11,118	Dues & Subscriptions	7,788		
TOTAL (agree to Schedule V, line 17, col. 1)				Pension	111,205	Advertising & Public Relations	28,624		
(List each licensed administrator separately.)			\$ 316,474	Employee Benefits	8,182				
B. Administrative - Other				Employment Screening	13,339	Home Office Allocation	6,199		
Description			Amount	Employment Recognition	2,312	Less: Public Relations Expense (			
Corporate Service Fee			\$ 99,606	Home Office Allocation	252,638	Non-allowable advertising	(24,766)		
Corporate IS Fee			149,786			Yellow page advertising	(3,173)		
Mgmt Fee			349,671	TOTAL (agree to Schedule V, line 22, col.8)			\$ 1,062,375		
Mgmt Fee Interest			207,804	TOTAL (agree to Sch. V, line 20, col. 8)			\$ 18,642		
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 806,867	E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
(Attach a copy of any management service agreement)				Description	Line #	Amount	G. Schedule of Travel and Seminar**		
C. Professional Services							Description	Amount	
Vendor/Payee	Type		Amount	N/A			Out-of-State Travel	\$	
Legal Expense	Various		\$ 2,182						
Survey & Analytical Tools	Various		5,266				In-State Travel	8,461	
Shredding/Storage	Various		3,516						
Care Counselor	Various		6,555				Seminar Expense		
Collections	Various		1,626				Home Office Allocation	4,755	
Outsourced Services	Various		1,430				Entertainment Expense (		
							(agree to Sch. V, line 24, col. 8)		
							TOTAL	\$ 13,216	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$			
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 20,575						

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name &amp; ID Number Provena Geneva Care Center

# 0043448

Report Period Beginning:

01/01/09

Ending:

12/31/09

**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 \$5312
- (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. \$ 63,410 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. \$ 58,583  
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. \$ 1,249
- (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
- (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.