FOR BHF USE

LL1

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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0043448

Facility Name: Provena Geneva Care Center

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

County: Kane

Telephone Number: (630) 232-7544 **Fax #** (630) 232-4409

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 C3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2010 to 12/31/2010 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Michael R. Gordon
(Title) CFO, VP of Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	10,435	3,595	5,497	19,527	8
9	SNF/PED					9
10	ICF	7,251	2,510		9,761	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,686	6,105	5,497	29,288	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.99%

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 [X]

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

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 [X] Date 3/1/1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 63 and days of care provided 4,825

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	245,451	30,700	17,724	293,875		293,875		293,875			1
2	Food Purchase		192,726		192,726		192,726	1,503	194,229			2
3	Housekeeping	97,268	12,877		110,145		110,145		110,145			3
4	Laundry	22,065	1,548	74,838	98,451		98,451		98,451			4
5	Heat and Other Utilities			96,372	96,372		96,372	6,088	102,460			5
6	Maintenance	52,667	21,436	75,323	149,426		149,426	53,152	202,578			6
7	Other (specify):* Pastoral	47,086	564	367	48,017		48,017		48,017			7
8	TOTAL General Services	464,537	259,851	264,624	989,012		989,012	60,743	1,049,755			8
	B. Health Care and Programs											
9	Medical Director			13,200	13,200		13,200		13,200			9
10	Nursing and Medical Records	2,351,477	204,805	106,327	2,662,609		2,662,609		2,662,609			10
10a	Therapy			536,544	536,544		536,544		536,544			10a
11	Activities	114,289	4,579	10,677	129,545		129,545	203	129,748			11
12	Social Services	32,440		2,129	34,569		34,569		34,569			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,498,206	209,384	668,877	3,376,467		3,376,467	203	3,376,670			16
	C. General Administration											
17	Administrative	320,081	20,887	819,236	1,160,204		1,160,204	(242,177)	918,027			17
18	Directors Fees											18
19	Professional Services			20,824	20,824		20,824	(62,453)	(41,629)			19
20	Dues, Fees, Subscriptions & Promotions			22,154	22,154		22,154	(12,189)	9,965			20
21	Clerical & General Office Expenses			22,289	22,289		22,289	6,094	28,383			21
22	Employee Benefits & Payroll Taxes			752,380	752,380		752,380	222,710	975,090			22
23	Inservice Training & Education			1,931	1,931		1,931	376	2,307			23
24	Travel and Seminar			7,456	7,456		7,456	3,467	10,923			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			132,402	132,402		132,402	(494)	131,908			26
27	Other (specify):* Bad Debt			54,143	54,143		54,143	(54,143)				27
28	TOTAL General Administration	320,081	20,887	1,832,815	2,173,783		2,173,783	(138,809)	2,034,974			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,282,824	490,122	2,766,316	6,539,262		6,539,262	(77,863)	6,461,399			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: 1/1/2010 Ending: 12/31/2010

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			308,472	308,472		308,472	78,838	387,310			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							436,835	436,835			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							19,552	19,552			34
35	Rent-Equipment & Vehicles			14,507	14,507		14,507	2,501	17,008			35
36	Other (specify):*											36
37	TOTAL Ownership			322,979	322,979		322,979	537,726	860,705			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			357,333	357,333		357,333	(186,753)	170,580			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			416,076	416,076		416,076	(186,753)	229,323			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,282,824	490,122	3,505,371	7,278,317		7,278,317	273,110	7,551,427			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: 1/1/2010 Ending: 12/31/2010

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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(977)	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	8,495	30		9
10	Interest and Other Investment Income	(10,708)	32		10
11	Discounts, Allowances, Rebates & Refunds	(186,753)	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	(54,143)	27		24
25	Fund Raising, Advertising and Promotional	(17,097)	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)**	$ (261,183)		$	30

BHF USE ONLY								
48		49		50		51		52	

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 Amount	2 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)	534,293		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 534,293		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 273,110		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 Yes	2 No	3 Amount	4 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

Provena Geneva Care Center

ID# 0043448

Report Period Beginning: 1/1/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
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				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Provena Geneva Care Center **#** 0043448 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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	(977)	2,480	0	0	0	0	0	0	0	0	0	1,503	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	6,088	0	0	0	0	0	0	0	0	0	6,088	5
6	Maintenance	0	1,140	52,012	0	0	0	0	0	0	0	0	53,152	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(977)	9,708	52,012	0	0	0	0	0	0	0	0	60,743	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	203	0	0	0	0	0	0	0	0	0	203	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	203	0	0	0	0	0	0	0	0	0	203	16
	C. General Administration													
17	Administrative	0	(346,071)	103,894	0	0	0	0	0	0	0	0	(242,177)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,018	(75,471)	0	0	0	0	0	0	0	0	(62,453)	19
20	Fees, Subscriptions & Promotions	(17,097)	4,908	0	0	0	0	0	0	0	0	0	(12,189)	20
21	Clerical & General Office Expenses	0	6,094	0	0	0	0	0	0	0	0	0	6,094	21
22	Employee Benefits & Payroll Taxes	0	57,473	165,237	0	0	0	0	0	0	0	0	222,710	22
23	Inservice Training & Education	0	376	0	0	0	0	0	0	0	0	0	376	23
24	Travel and Seminar	0	3,467	0	0	0	0	0	0	0	0	0	3,467	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	(494)	0	0	0	0	0	0	0	0	0	(494)	26
27	Other (specify):*	(54,143)	0	0	0	0	0	0	0	0	0	0	(54,143)	27
28	**TOTAL General Administration**	(71,240)	(261,229)	193,660	0	0	0	0	0	0	0	0	(138,809)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,217)	(251,318)	245,672	0	0	0	0	0	0	0	0	(77,863)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Geneva Care Center # 0043448 **Report Period Beginning:** 1/1/2010 **Ending:** 12/31/2010

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	8,495	0	70,343	0	0	0	0	0	0	0	0	78,838	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,708)	0	447,543	0	0	0	0	0	0	0	0	436,835	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	19,552	0	0	0	0	0	0	0	0	19,552	34
35	Rent-Equipment & Vehicles	0	0	2,501	0	0	0	0	0	0	0	0	2,501	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,213)	0	539,939	0	0	0	0	0	0	0	0	537,726	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	(186,753)	0	0	0	0	0	0	0	0	0	0	(186,753)	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**	(186,753)	0	0	0	0	0	0	0	0	0	0	(186,753)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(261,183)	(251,318)	785,611	0	0	0	0	0	0	0	0	273,110	45

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Food	$	Provena Senior Services	100.00%	$ 2,480	$ 2,480	1
2	V	5	Utilities		Provena Senior Services	100.00%	6,088	6,088	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	1,140	1,140	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	203	203	4
5	V	17	Admin - Misc. Other		Provena Senior Services	100.00%	4,448	4,448	5
6	V	17	Administrative Salaries	582,600	Provena Senior Services	100.00%	232,081	(350,519)	6
7	V	19	Professional Services		Provena Senior Services	100.00%	13,018	13,018	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	4,908	4,908	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	6,094	6,094	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	57,473	57,473	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	376	376	11
12	V	24	Travel		Provena Senior Services	100.00%	3,467	3,467	12
13	V	26	Insurance		Provena Senior Services	100.00%	(494)	(494)	13
14	Total			$ 582,600			$ 331,282	$ * (251,318)	14

*** 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: 1/1/2010 Ending: 12/31/2010

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Provena Senior Services	100.00%	$ 3,082	$ 3,082	15
16	V	32	Interest		Provena Senior Services	100.00%	255,400	255,400	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	19,552	19,552	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	2,501	2,501	18
19	V	17	Admin Salaries		Provena Health Services	100.00%	82,482	82,482	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	56,565	56,565	20
21	V	30	Depreciation		Provena Health Services	100.00%	67,261	67,261	21
22	V	19	Admin Consulting,Other	96,880	Provena Health Services	100.00%	21,409	(75,471)	22
23	V	17	Information Systems Salaries		Provena Health Services	100.00%	85,818	85,818	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	29,660	29,660	24
25	V	17	Information Systems - Other	139,756	Provena Health Services	100.00%	27,618	(112,138)	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	12,833	12,833	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	49,740	49,740	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	34,899	34,899	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	29,272	29,272	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	52,012	52,012	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	192,143	192,143	31
32	V	39	Ancillary Services - Other	357,333	Provena Senior Services Pharmacy	100.00%	357,333		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 593,969			$ 1,379,580	$ * 785,611	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: 1/1/2010 Ending: 12/31/2010

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		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: 1/1/2010 Ending: 2/31/2010

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 [X] NO [ ]

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

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Molkena, IL 60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	6,595,714	19	$ 28,071	$	582,600	$ 2,480	1
2	5	Utilities	Management Fee Income	6,595,714	19	68,922		582,600	6,088	2
3	6	Maintenance - Other	Management Fee Income	6,595,714	19	12,909		582,600	1,140	3
4	11	Activities-Special Events	Management Fee Income	6,595,714	19	2,299		582,600	203	4
5	17	Admin - Misc. Other	Management Fee Income	6,595,714	19	50,355		582,600	4,448	5
6	17	Administrative Salaries	Management Fee Income	6,595,714	19	2,627,432	2,627,432	582,600	232,081	6
7	19	Professional Services	Management Fee Income	6,595,714	19	147,379		582,600	13,018	7
8	20	Dues,Subscriptions	Management Fee Income	6,595,714	19	55,559		582,600	4,908	8
9	21	Clerical Supplies	Management Fee Income	6,595,714	19	68,996		582,600	6,094	9
10	22	Employee Benefits	Management Fee Income	6,595,714	19	650,662		582,600	57,473	10
11	23	Education/Conference	Management Fee Income	6,595,714	19	4,261		582,600	376	11
12	24	Travel	Management Fee Income	6,595,714	19	39,252		582,600	3,467	12
13	26	Insurance	Management Fee Income	6,595,714	19	(5,591)		582,600	(494)	13
14	30	Depreciation	Management Fee Income	6,595,714	19	34,889		582,600	3,082	14
15	32	Interest	Management Fee Income	6,595,714	19	2,891,431		582,600	255,400	15
16	34	Rent - Facility	Management Fee Income	6,595,714	19	221,352		582,600	19,552	16
17	35	Rent - Equipment	Management Fee Income	6,595,714	19	28,311		582,600	2,501	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,926,489	$ 2,627,432		$ 611,817	25

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] 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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,061,750	10	$ 903,952	$ 903,952	96,880	$ 82,482	1
2	22	Employee Benefits	Operating Expense	1,061,750	10	619,921		96,880	56,565	2
3	30	Depreciation	Operating Expense	1,061,750	10	737,143		96,880	67,261	3
4	34	Rent Facility	Operating Expense	1,061,750	10	234,632		96,880	21,409	4
5	19	Admin Consulting,Other	Operating Expense	1,061,750	10	940,516		96,880	85,818	5
6	17	Information Systems Salaries	Operating Expense	1,712,144	10	363,360	363,360	139,756	29,660	6
7	22	Information Systems Benefits	Operating Expense	1,712,144	10	338,352		139,756	27,618	7
8	17	Information Systems - Other	Operating Expense	1,712,144	10	157,216		139,756	12,833	8
9	17	Admin Salaries	Direct Cost	1,061,750	10	545,118	545,118	96,880	49,740	9
10	17	Information Systems Salaries	Direct Cost	1,712,144	10	427,541	427,541	139,756	34,899	10
11	6	Information Systems - Equip Mair	Direct Cost	1,712,144	10	358,615		139,756	29,272	11
12	19	Admin Consulting,Other	Direct Cost	1,061,750	10	570,021		96,880	52,012	12
13	32	Admin - Interest Expense	Direct Cost	1,061,750	10	2,105,774		96,880	192,143	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					$ 8,302,161	$ 2,239,971		$ 741,712	25

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 2/31/2010

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 [X] 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 Dr.
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Allocation			$	$		$ 357,333	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					$	$		$ 357,333	25

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Home Office Allocation						$	$			$ 447,543	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 447,543	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 447,543	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:** 1/1/2010 **Ending:** 12/31/2010

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2005	8
	2006	9
	2007	10
	2008	11
	2009	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2009 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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 and 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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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: 1/1/2010 Ending: 12/31/2010

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? [X] (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? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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 [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 750,000	1
2					2
3	TOTALS			$ 750,000	3

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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	$	$ 2,083,333	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various										9
10	Various			1999	6,592		7			20,948	10
11	Various			2000	5,712	286	8	286		5,712	11
12	Various			2001	638,937	25,658	27	25,658		245,296	12
13	Various			2002	1,368	22	13	22		1,009	13
14	Various			2003	74,217	6,201	12	6,201		49,656	14
15	Various			2004	116,028	7,534	9	7,534		82,928	15
16	Various			2005	40,779	4,159	9	4,159		25,210	16
17	Various			2006	47,925	6,430	9	6,430		28,555	17
18											18
19	PHONE SYSTEM PORT INSTALLATION			2007	1,712	171	10	171		599	19
20	25 TRANECOOLING UNITS			2007	44,862	2,991	15	2,991		10,468	20
21	CONVERSION OF ICF TO SNF			2007	3,280	219	15	219		755	21
22	MEETING ROOM REMODEL			2007	20,058	1,337	15	1,337		4,680	22
23	RESURFACE/OVERLAY/REPAIR PARKING LOT			2007	50,590	6,324	8	6,324		22,133	23
24	FRONT ENTRY REMODEL			2007	46,575	4,658	10	4,658		16,151	24
25											25
26	CINEMA SYSTEM			2008	22,305	3,186	7	3,186		7,169	26
27											27
28	STAIRWELLREPAIRS (FIRE RATED LIFE S			2009	3,200	640	5	640		960	28
29	ELECTRICPANEL/CIRCUIT BREAKER			2009	2,750	183	15	183		275	29
30	SATELITETV			2009	1,865	266	7	266		353	30
31	NATURAL OAK VINYL FLOORINGFOR LOWER			2009	45,100	4,510	10	4,510		6,765	31
32	UPGRADE NURSE AREA			2009	3,710	371	10	371		371	32
33	WATERPROOFING WORK			2009	7,600	507	15	507		507	33
34	ADDITIONOF PHONE LINES			2009	4,781	478	10	478		478	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: 1/1/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SHOWER BATH SPA SETTING	2010	$ 17,395	$ 870	10	$ 1,739	$ 870	$ 870	37
38	DIETARY EQUIPMENT UPGRADE -SINK DRYE	2010	14,677	1,048	7	2,097	1,048	1,048	38
39	ELEVATORREPAIR - REPLACE HYDAULIC C	2010	62,850	3,143	10	6,285	3,143	3,143	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,284,868	$ 247,858		$ 252,918	$ 5,061	$ 2,619,374	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: 1/1/2010 Ending: 12/31/2010

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	$ 639,849	$ 57,181	$ 57,181	$	13	$ 296,066	71
72	Current Year Purchases	45,004	3,434	6,869	3,434	7	3,434	72
73	Fully Depreciated Assets	847,784				10	847,784	73
74	Home Office Allocation		70,343	70,343				74
75	TOTALS	$ 1,532,637	$ 130,958	$ 134,392	$ 3,434		$ 1,147,284	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)	$ 8,567,506	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 378,815	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 387,310	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,495	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,766,658	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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				19,552			5
6								6
7	TOTAL				$ 19,552 **			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 [X] NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO
16. Rental Amount for movable equipment: $ 99,026 Description: Nurse $77,827; Activities $91; Diet $2,708; Laundry $1,392; Admin $14,507; Home Off $2501
(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: 1/1/2010 Ending: 12/31/2010

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		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: 1/1/2010 Ending: 12/31/2010

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	2,470	$ 176,602	$	2,470	$ 176,602	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		1,313	101,761		1,313	101,761	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		3,497	258,181		3,497	258,181	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				357,333		357,333	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			$	7,280	$ 536,544	$ 357,333	7,280	$ 893,877	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.

STATE OF ILLINOIS

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2010 (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	$ 12,905,317	$	1
2	Cash-Patient Deposits	106,041		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	11,828,283		3
4	Supply Inventory (priced at)	704,078		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	214,949		7
8	Accounts Receivable (owners or related parties)	49,434		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 25,808,102	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,146,223		12
13	Land	6,880,789		13
14	Buildings, at Historical Cost	88,483,063		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	20,359,968		16
17	Accumulated Depreciation (book methods)	(60,063,987)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 63,806,056	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 89,614,158	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,914,297	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,171,680		28
29	Short-Term Notes Payable	56,068		29
30	Accrued Salaries Payable	3,651,233		30
31	Accrued Taxes Payable (excluding real estate taxes)	120,716		31
32	Accrued Real Estate Taxes(Sch.IX-B)	1,242,086		32
33	Accrued Interest Payable	12,331		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	1,099,900		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 13,268,311	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,108,871		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	442,616		42
	Other Long-Term Liabilities(specify):			
43	Conditional Asset Retirement	438,744		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,990,231	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 15,258,542	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 74,355,616	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 89,614,158	$	48

*(See instructions.)

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 73,769,457	1
2	Restatements (describe):		2
3	**Transfer to Affiliates**	(2,072,160)	3
4	**Adj. To reconcile consolidated equity & consolidated income**	3,137,833	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 74,835,130	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(591,206)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	232,870	11
12	Expenditures for Specific Purposes	(121,178)	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)**	$ (479,514)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 74,355,616	24 *

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,009,092	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,009,092	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,079,728	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,079,728	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	2,448	13
14	Non-Patient Meals	977	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	312,260	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	198	20
21	Other Medical Services		21
22	Laundry	29,350	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 345,233	23
	D. Non-Operating Revenue		
24	Contributions	48,741	24
25	Interest and Other Investment Income***	10,708	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,449	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Purchase Rebates	186,753	28
28a	Misc Income & Gain/Loss SOFA	6,856	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 193,609	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,687,111	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	989,012	31
32	Health Care	3,376,467	32
33	General Administration	2,173,783	33
	B. Capital Expense		
34	Ownership	322,979	34
	C. Ancillary Expense		
35	Special Cost Centers	357,333	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)***	$ 7,278,317	40
41	**Income before Income Taxes (line 30 minus line 40)****	(591,206)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (591,206)	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: 1/1/2010 Ending: 12/31/2010

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,792	2,053	$ 85,393	$ 41.59	1
2	Assistant Director of Nursing	1,880	1,992	55,899	28.06	2
3	Registered Nurses	15,214	17,223	540,276	31.37	3
4	Licensed Practical Nurses	19,699	21,288	566,922	26.63	4
5	CNAs & Orderlies	64,934	70,081	1,029,542	14.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,798	5,477	73,445	13.41	8
9	Activity Director	1,864	2,072	41,192	19.88	9
10	Activity Assistants	5,420	6,279	73,097	11.64	10
11	Social Service Workers	1,457	1,702	32,440	19.06	11
12	Dietician					12
13	Food Service Supervisor	2,296	2,424	43,688	18.02	13
14	Head Cook	7,110	7,789	97,160	12.47	14
15	Cook Helpers/Assistants	10,538	11,083	104,603	9.44	15
16	Dishwashers					16
17	Maintenance Workers	2,597	2,820	52,667	18.68	17
18	Housekeepers	8,529	9,264	97,268	10.50	18
19	Laundry	2,282	2,535	22,065	8.70	19
20	Administrator	2,032	2,112	115,481	54.68	20
21	Assistant Administrator					21
22	Other Administrative	3,576	4,072	76,800	18.86	22
23	Office Manager					23
24	Clerical	4,339	4,721	43,029	9.11	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 C: Admissions	4,020	4,544	84,771	18.66	32
33	Other(specify) Pastoral	1,912	2,080	47,086	22.64	33
34	TOTAL (lines 1 - 33)	166,289	181,611	$ 3,282,824 *	$ 18.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	115	$ 7,171	1,3	35
36	Medical Director	88	13,200	9,3	36
37	Medical Records Consultant	21	2,010	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	46	2,448	11,3	44
45	Social Service Consultant	35	2,130	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	305	$ 26,959		49

C. CONTRACT NURSES

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dawn Renee Furman	Admisistrator	0	$ 115,481
Admisistrative Staff	Human Resources	0	44,104
Admisistrative Staff	Bookkeeper	0	32,696
Admisistrative Staff	Receptionist	0	43,029
Admisistrative Staff	Admin Asst	0	
Admisistrative Staff	Admissions	0	84,771
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 320,081

B. Administrative - Other

Description	Amount
Corporate Service Fee	$ 96,880
Corporate IS Fee	139,756
Mgmt Fee	321,204
Mgmt Fee Interest	261,396
TOTAL (agree to Schedule V, line 17, col. 3)	$ 819,236
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 4,583
Survey & Analytical Tools	Various	4,595
Shredding/Storage	Various	4,718
Audit Expense	Various	4,000
Collections	Various	912
Outsourced Services	Various	2,016
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 20,824

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 98,796
Unemployment Compensation Insurance	33,264
FICA Taxes	241,434
Employee Health Insurance	238,561
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	12,041
Pension	108,237
Executive Benefits	8,494
Employment Screening	10,439
Employment Recognition	1,114
Home Office Allocation	222,710
TOTAL (agree to Schedule V, line 22, col.8)	$ 975,090

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 37)	
Patient Background Checks 131	
Employee Recruitment	
Dues & Subscriptions	4,254
Advertising & Public Relations	17,900
Home Office Allocation	4,908
Less: Public Relations Expense	( )
Non-allowable advertising	(17,097)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,965

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 351
In-State Travel	7,105
Seminar Expense	
Home Office Allocation	3,467
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,923

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 1/1/2010 Ending: 12/31/2010

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 $5,937**

(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? **No** If YES, what is the capacity? **N/A**

(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. $ **66,899** 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. $ **977**

(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.