

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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

I. IDPH License ID Number: <u>0043448</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Provena Geneva Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2011</u> to <u>07/08/2011</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. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>1101 E. State Street</u> <u>Geneva</u> <u>60134</u>																																																	
Number City Zip Code																																																	
County: <u>Kane</u>																																																	
Telephone Number: <u>(630) 232-7544</u> Fax # <u>(630) 232-4409</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Michael R. Gordon</u></td></tr><tr><td>(Title) <u>CFO, VP of Finance</u></td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) _____</td></tr><tr><td>(Firm Name & Address) _____</td></tr><tr><td>(Telephone) <u>()</u> Fax # <u>()</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Michael R. Gordon</u>	(Title) <u>CFO, VP of Finance</u>	(Date) _____	Paid Preparer	(Signed) _____	(Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # <u>()</u>																																			
Officer or Administrator of Provider	(Signed) _____																																																
	(Type or Print Name) <u>Michael R. Gordon</u>																																																
	(Title) <u>CFO, VP of Finance</u>																																																
	(Date) _____																																																
Paid Preparer	(Signed) _____																																																
	(Date) _____																																																
	(Print Name and Title) _____																																																
	(Firm Name & Address) _____																																																
	(Telephone) <u>()</u> Fax # <u>()</u>																																																
Date of Initial License for Current Owners: <u>03/01/98</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td colspan="2">IRS Exemption Code <u>501 C3</u></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td colspan="2"></td><td>☐</td><td>"Sub-S" Corp.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Limited Liability Co.</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Trust</td><td colspan="2">_____</td></tr><tr><td colspan="2"></td><td>☐</td><td>Other</td><td colspan="2">_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501 C3</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	_____				☐	Limited Liability Co.	_____				☐	Trust	_____				☐	Other	_____	
☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL																																												
☒	Charitable Corp.	☐	Individual	☐	State																																												
☐	Trust	☐	Partnership	☐	County																																												
IRS Exemption Code <u>501 C3</u>		☐	Corporation	☐	Other _____																																												
		☐	"Sub-S" Corp.	_____																																													
		☐	Limited Liability Co.	_____																																													
		☐	Trust	_____																																													
		☐	Other	_____																																													
In the event there are further questions about this report, please contact:		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																																															
Name: <u>Lynda Olinski</u>																																																	
Telephone Number: <u>(708) 478-7916</u>																																																	
Email Address: _____																																																	

Facility Name & ID Number Provena Geneva Care Center

0043448 Report Period Beginning: 01/01/2011 Ending: 07/08/2011

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>63</u>	Skilled (SNF)	<u>63</u>	<u>11,907</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>44</u>	Intermediate (ICF)	<u>44</u>	<u>8,316</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>107</u>	TOTALS	<u>107</u>	<u>20,223</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,324</u>	<u>1,176</u>	<u>2,191</u>	<u>8,691</u>	8
9	SNF/PED					9
10	ICF	<u>5,116</u>	<u>1,129</u>		<u>6,245</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,440</u>	<u>2,305</u>	<u>2,191</u>	<u>14,936</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.86%

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

03/01/1998

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

1,946

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: 12/31/11

Fiscal Year: 07/08/11

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

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/2011 Ending: 07/08/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	132,167	14,077	8,350	154,594		154,594		154,594			1
2	Food Purchase		96,191		96,191		96,191	2,484	98,675			2
3	Housekeeping	57,621	7,903		65,524		65,524		65,524			3
4	Laundry	12,833	(210)	41,751	54,374		54,374		54,374			4
5	Heat and Other Utilities			52,137	52,137		52,137	5,261	57,398			5
6	Maintenance	22,463	(609)	53,943	75,797		75,797	58,058	133,855			6
7	Other (specify):* Pastoral Care	24,717	114	10,638	35,469		35,469		35,469			7
8	TOTAL General Services	249,801	117,466	166,819	534,086		534,086	65,803	599,889			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,228,339	93,443	52,321	1,374,103		1,374,103		1,374,103			10
10a	Therapy			212,882	212,882		212,882		212,882			10a
11	Activities	65,697	3,285	1,570	70,552		70,552	1,644	72,196			11
12	Social Services	28,985		1,028	30,013		30,013		30,013			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,323,021	96,728	275,001	1,694,750		1,694,750	1,644	1,696,394			16
	C. General Administration											
17	Administrative	142,934	7,625	756,502	907,061		907,061	(252,334)	654,727			17
18	Directors Fees											18
19	Professional Services			16,757	16,757		16,757	52,149	68,906			19
20	Dues, Fees, Subscriptions & Promotions			5,995	5,995		5,995	5,492	11,487			20
21	Clerical & General Office Expenses			14,334	14,334		14,334	5,535	19,869			21
22	Employee Benefits & Payroll Taxes			533,504	533,504		533,504	227,258	760,762			22
23	Inservice Training & Education			375	375		375	3,799	4,174			23
24	Travel and Seminar			4,939	4,939		4,939	3,566	8,505			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			85,769	85,769		85,769	(549)	85,220			26
27	Other (specify):* Bad Debt			142,066	142,066		142,066		142,066			27
28	TOTAL General Administration	142,934	7,625	1,560,241	1,710,800		1,710,800	44,916	1,755,716			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,715,756	221,819	2,002,061	3,939,636		3,939,636	112,363	4,051,999			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			158,049	158,049		158,049	82,156	240,205			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							419,464	419,464			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							14,377	14,377			34
35	Rent-Equipment & Vehicles			4,954	4,954		4,954	2,405	7,359			35
36	Other (specify):*											36
37	TOTAL Ownership			163,003	163,003		163,003	518,402	681,405			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			134,580	134,580		134,580		134,580			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,051	29,051		29,051		29,051			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			163,631	163,631		163,631		163,631			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,715,756	221,819	2,328,695	4,266,270		4,266,270	630,765	4,897,035			45

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

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				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				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				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)	\$		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$		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.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID#0043448

01/01/2011

07/08/2011

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

Summary A

07/08/2011

[illegible]

Summary B

07/08/2011

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

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

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%	\$ 2,484	\$ 2,484	1
2	V	5	Utilities		Provena Senior Services	100.00%	5,261	5,261	2
3	V	6	Maintenance - Other		Provena Senior Services	100.00%	1,255	1,255	3
4	V	11	Activities-Special Events		Provena Senior Services	100.00%	1,644	1,644	4
5	V	17	Admin - Misc. Other		Provena Senior Services	100.00%	5,185	5,185	5
6	V	17	Administrative Salaries	540,300	Provena Senior Services	100.00%	256,366	(283,934)	6
7	V	19	Professional Services		Provena Senior Services	100.00%	27,800	27,800	7
8	V	20	Dues,Subscriptions		Provena Senior Services	100.00%	5,492	5,492	8
9	V	21	Clerical Supplies		Provena Senior Services	100.00%	5,535	5,535	9
10	V	22	Employee Benefits		Provena Senior Services	100.00%	59,307	59,307	10
11	V	23	Education/Conference		Provena Senior Services	100.00%	3,799	3,799	11
12	V	24	Travel		Provena Senior Services	100.00%	3,566	3,566	12
13	V	26	Insurance		Provena Senior Services	100.00%	(549)	(549)	13
14	Total			\$ 540,300			\$ 377,145	\$ * (163,155)	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%	\$ 3,163	\$ 3,163	15
16	V	32	Interest		Provena Senior Services	100.00%	209,622	209,622	16
17	V	34	Rent - Facility		Provena Senior Services	100.00%	14,377	14,377	17
18	V	35	Rent - Equipment		Provena Senior Services	100.00%	2,405	2,405	18
19	V	17	Admin Salaries	105,804	Provena Health Services	100.00%	95,737	(10,067)	19
20	V	22	Employee Benefits		Provena Health Services	100.00%	62,986	62,986	20
21	V	30	Depreciation		Provena Health Services	100.00%	78,993	78,993	21
22	V	19	Admin Consulting, Other		Provena Health Services	100.00%	24,349	24,349	22
23	V	17	Information Systems Salaries	126,804	Provena Health Services	100.00%	94,919	(31,885)	23
24	V	22	Information Systems Benefits		Provena Health Services	100.00%	26,911	26,911	24
25	V	17	Information Systems - Other		Provena Health Services	100.00%	25,059	25,059	25
26	V	17	Admin Salaries		Provena Health Services	100.00%	11,644	11,644	26
27	V	22	Employee Benefits		Provena Health Services	100.00%	51,494	51,494	27
28	V	17	Information Systems Salaries		Provena Health Services	100.00%	31,664	31,664	28
29	V	22	Information Systems Benefits		Provena Health Services	100.00%	26,560	26,560	29
30	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	56,803	56,803	30
31	V	32	Admin - Interest Expense		Provena Health Services	100.00%	209,842	209,842	31
32	V	39	Ancillary Services - Other	135,086	Provena Senior Services Pharmacy	100.00%	135,086		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 367,694			\$ 1,161,614	\$ * 793,920	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

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

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: 01/01/2011 Ending: 7/08/2011

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 Life Connections
Street Address 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code Mokena, IL60448
Phone Number (708)478-7900
Fax Number (708)478-5387

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	2	Food	Management Fee Income	6,978,684	19	\$ 32,085	\$	540,300	\$ 2,484	1
2	5	Utilities	Management Fee Income	6,978,684	19	67,947		540,300	5,261	2
3	6	Maintenance - Other	Management Fee Income	6,978,684	19	16,212		540,300	1,255	3
4	11	Activities-Special Events	Management Fee Income	6,978,684	19	21,233		540,300	1,644	4
5	17	Admin - Misc. Other	Management Fee Income	6,978,684	19	66,972		540,300	5,185	5
6	17	Administrative Salaries	Management Fee Income	6,978,684	19	3,311,304	3,311,304	540,300	256,366	6
7	19	Professional Services	Management Fee Income	6,978,684	19	359,072		540,300	27,800	7
8	20	Dues,Subscriptions	Management Fee Income	6,978,684	19	70,930		540,300	5,492	8
9	21	Clerical Supplies	Management Fee Income	6,978,684	19	71,493		540,300	5,535	9
10	22	Employee Benefits	Management Fee Income	6,978,684	19	766,023		540,300	59,307	10
11	23	Education/Conference	Management Fee Income	6,978,684	19	49,066		540,300	3,799	11
12	24	Travel	Management Fee Income	6,978,684	19	46,061		540,300	3,566	12
13	26	Insurance	Management Fee Income	6,978,684	19	(7,088)		540,300	(549)	13
14	30	Depreciation	Management Fee Income	6,978,684	19	40,850		540,300	3,163	14
15	32	Interest	Management Fee Income	6,978,684	19	2,707,546		540,300	209,622	15
16	34	Rent - Facility	Management Fee Income	6,978,684	19	185,702		540,300	14,377	16
17	35	Rent - Equipment	Management Fee Income	6,978,684	19	31,060		540,300	2,405	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 7,836,468	\$ 3,311,304		\$ 606,712	25

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/2011 Ending: 7/08/2011

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		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	17	Admin Salaries	Operating Expense	1,061,750	10	\$ 960,727	\$ 960,727	105,804	\$ 95,737	1
2	22	Employee Benefits	Operating Expense	1,061,750	10	632,071		105,804	62,986	2
3	30	Depreciation	Operating Expense	1,061,750	10	792,695		105,804	78,993	3
4	34	Rent Facility	Operating Expense	1,061,750	10	244,345		105,804	24,349	4
5	19	Admin Consulting,Other	Operating Expense	1,061,750	10	952,517		105,804	94,919	5
6	17	Information Systems Salaries	Operating Expense	1,712,144	10	363,360	363,360	126,804	26,911	6
7	22	Information Systems Benefits	Operating Expense	1,712,144	10	338,352		126,804	25,059	7
8	17	Information Systems - Other	Operating Expense	1,712,144	10	157,216		126,804	11,644	8
9	17	Admin Salaries	Direct Cost	1,061,750	10	516,745	516,745	105,804	51,494	9
10	17	Information Systems Salaries	Direct Cost	1,712,144	10	427,541	427,541	126,804	31,664	10
11	6	Information Systems - Equip Maint	Direct Cost	1,712,144	10	358,615		126,804	26,560	11
12	19	Admin Consulting,Other	Direct Cost	1,061,750	10	570,021		105,804	56,803	12
13	32	Admin - Interest Expense	Direct Cost	1,061,750	10	2,105,774		105,804	209,842	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					\$ 8,419,979	\$ 2,268,373		\$ 796,961	25

Facility Name & ID Number Provena Geneva Care Center # 0043448 Report Period Beginning: 01/01/2011 Ending: 7/08/2011

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 670 North Convent Street
City / State / Zip Code Bourbonnais, IL 60914
Phone Number (815)936-3644
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			\$	\$		\$ 135,086	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					\$	\$		\$ 135,086	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2010 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 2011 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:	2006		8		
	2007		9		
	2008		10		
	2009		11		
	2010		12		

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Provena Geneva Care Center</u>	COUNTY	<u>Kane</u>
---------------	-----------------------------------	--------	-------------

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 2010 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 2010.

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

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ **B. General Construction Type:** _____ **Exterior** _____ **Frame** _____ **Number of Stories** _____

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

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

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

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

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

[illegible]

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-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					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
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

*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 and Improvement Costs-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			\$	\$		\$	\$		37
38									38
39									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)		\$	\$		\$	\$	\$	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-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	\$	\$	\$	\$		\$	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$	\$	\$	\$		\$	75

D. Vehicle Costs. (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)	\$	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	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								5
6								6
7	TOTAL				\$			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: \$
- Description:

(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.	/2012	\$
13.	/2013	\$
14.	/2014	\$

* 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.

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

☐ 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

C. CONTRACTUAL INCOME

D. NUMBER OF CNAs TRAINED

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			\$		\$	\$		\$	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 07/08/2011

(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	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			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)	\$	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (265,123)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (265,123)	\$	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(265,123)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		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)	\$ (265,123)	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)	\$ (265,123)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Provena Geneva Care Center# 0043448Report Period Beginning: 01/01/2011Ending: 07/08/2011

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

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

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,454,621	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,454,621	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	407,807	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 407,807	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,180	13
14	Non-Patient Meals	870	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	108,526	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,940	20
21	Other Medical Services		21
22	Laundry	17,380	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 129,896	23
	D. Non-Operating Revenue		
24	Contributions	13,292	24
25	Interest and Other Investment Income***	3,977	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 17,269	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Gain/Loss Sale of Business Assets</u>	886,177	28
28a	<u>Purchase Rebates/Misc. Income</u>	105,377	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 991,554	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 4,001,147	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	534,086	31
32	Health Care	1,694,750	32
33	General Administration	1,710,800	33
	B. Capital Expense		
34	Ownership	163,003	34
	C. Ancillary Expense		
35	Special Cost Centers	134,580	35
36	Provider Participation Fee	29,051	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,266,270	40
41	Income before Income Taxes (line 30 minus line 40)**	(265,123)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (265,123)	43

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

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

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

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

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	1,056	1,146	\$ 57,857	\$ 50.49	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,156	12,670	384,684	30.36	3
4	Licensed Practical Nurses	7,604	9,007	232,646	25.83	4
5	CNAs & Orderlies	31,964	35,990	509,354	14.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,086	2,277	31,747	13.94	8
9	Activity Director	928	1,127	22,396	19.87	9
10	Activity Assistants	3,117	3,512	43,300	12.33	10
11	Social Service Workers	1,064	1,310	28,985	22.13	11
12	Dietician					12
13	Food Service Supervisor	1,250	1,336	25,954	19.43	13
14	Head Cook	3,622	3,981	50,346	12.65	14
15	Cook Helpers/Assistants	5,728	6,157	55,867	9.07	15
16	Dishwashers					16
17	Maintenance Workers	1,024	1,151	22,463	19.52	17
18	Housekeepers	4,764	5,349	57,621	10.77	18
19	Laundry	1,329	1,440	12,833	8.91	19
20	Administrator	1,016	1,139	35,217	30.92	20
21	Assistant Administrator					21
22	Other Administrative	1,956	2,145	34,064	15.88	22
23	Office Manager					23
24	Clerical	2,123	2,421	27,640	11.42	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	392	440	12,051	27.39	31
32	Other Health Care Admissions	2,024	2,348	46,013	19.60	32
33	Other(specify) Pastoral Care	960	1,197	24,717	20.65	33
34	TOTAL (lines 1 - 33)	85,163	96,143	\$ 1,715,755 *	\$ 17.85	34

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		\$		35
36	Medical Director				36
37	Medical Records Consultant				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				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$		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

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

** See instructions.

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
			\$	Workers' Compensation Insurance	\$		IDPH License Fee	\$
				Unemployment Compensation Insurance			Advertising: Employee Recruitment	
				FICA Taxes			Health Care Worker Background Check	
				Employee Health Insurance			(Indicate # of checks performed)	
				Employee Meals			Patient Background Checks	
				Illinois Municipal Retirement Fund (IMRF)*				
TOTAL (agree to Schedule V, line 17, col. 1)			\$					
(List each licensed administrator separately.)								
B. Administrative - Other								
Description			Amount				Less: Public Relations Expense	()
			\$				Non-allowable advertising	()
							Yellow page advertising	()
				TOTAL (agree to Schedule V,	\$		TOTAL (agree to Sch. V,	\$
				line 22, col.8)			line 20, col. 8)	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				to Owners or Employees			Description	Amount
C. Professional Services				Description	Line #	Amount		
Vendor/Payee	Type		Amount			\$	Out-of-State Travel	\$
			\$					
							In-State Travel	
							Seminar Expense	
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)			\$	TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$5,000, attach copy of invoices.)							line 24, col. 8)	\$

* Attach copy of IMRF notifications

**See instructions.

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 Services Network

(3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

If YES, what is the capacity?

(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?

(6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

Line

(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.

(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.
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$

29,051

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.

\$

Has any meal income been offset against related costs?

Indicate the amount.

\$

(16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

d. Have vehicle usage logs been maintained?

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

g. Does the facility transport residents to and from day training?

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(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 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?

Attach invoices and a summary of services for all architect and appraisal fees.