

		FOR BHF USE					

LL1

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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>0025577</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																																	
Facility Name: <u>Covenant Health Care Center - Batavia</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>02/01/11</u> to <u>01/31/12</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>831 North Batavia Avenue</u> <u>Batavia</u> <u>60510</u>																																																			
Number City Zip Code																																																			
County: <u>Kane</u>																																																			
Telephone Number: <u>(630) 879-4300</u> Fax # <u>(630) 879-8483</u>																																																			
HFS ID Number: _____																																																			
Date of Initial License for Current Owners: <u>05/9/1980</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 _____</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 _____		☐	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 _____		☐	Corporation	☐	Other _____																																														
		☐	"Sub-S" Corp.	_____																																															
		☐	Limited Liability Co.	_____																																															
		☐	Trust																																																
		☐	Other _____																																																
In the event there are further questions about this report, please contact:																																																			
Name: <u>Andrew Cutler</u>																																																			
Telephone Number: <u>(847) 940-3269</u>																																																			
Email Address: _____																																																			
		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="5">Paid Preparer</td><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Andrew B. Cutler</u></td></tr><tr><td colspan="2">(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015</u></td></tr><tr><td colspan="2">(Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</u></td></tr><tr><td colspan="2">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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) _____	(Title) _____	(Signed) _____	(Date) _____	(Print Name and Title) <u>Andrew B. Cutler</u>	(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015</u>		(Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</u>		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																																		
Officer or Administrator of Provider	(Signed) _____																																																		
	(Date) _____																																																		
Paid Preparer	(Type or Print Name) _____																																																		
	(Title) _____																																																		
	(Signed) _____																																																		
	(Date) _____																																																		
	(Print Name and Title) <u>Andrew B. Cutler</u>																																																		
(Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015</u>																																																			
(Telephone) <u>(847) 374-0400</u> Fax # <u>(847) 374-0420</u>																																																			
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 Covenant Health Care Center - Batavia

0025577 Report Period Beginning: 02/01/11 Ending: 01/31/12

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 <u>N/A</u>					
	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>99</u>	Skilled (SNF)	<u>99</u>	<u>36,135</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,135</u>	7

B. Census-For the entire report period.					
	1	2	3	4	5
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Medicaid Recipient	Private Pay	Other	Total
8	SNF	<u>9,727</u>	<u>6,565</u>	<u>15,604</u>	<u>31,896</u>
9	SNF/PED				
10	ICF				
11	ICF/DD				
12	SC				
13	DD 16 OR LESS				
14	TOTALS	<u>9,727</u>	<u>6,565</u>	<u>15,604</u>	<u>31,896</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.27%

D. How many bed-hold days during this year were paid by the Department?
None (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)
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 05/06/1980

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/06/1980 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 99 and days of care provided 4,129

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 1/31 Fiscal Year: 1/31

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

Facility Name & ID Number Covenant Health Care Center - Batavia # 0025577 Report Period Beginning: 02/01/11 Ending: 01/31/12
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	342,800	39,317	67,283	449,400		449,400	(13,105)	436,295			1
2	Food Purchase		287,929		287,929		287,929	(2,874)	285,055			2
3	Housekeeping	131,242		2,230	133,472		133,472		133,472			3
4	Laundry	55,426	298	41,086	96,810		96,810		96,810			4
5	Heat and Other Utilities			149,781	149,781		149,781		149,781			5
6	Maintenance	212,449		111,511	323,960		323,960	(2,165)	321,795			6
7	Other (specify):*											7
8	TOTAL General Services	741,917	327,544	371,891	1,441,352		1,441,352	(18,144)	1,423,208			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,720,985	59,494	70,719	2,851,198		2,851,198		2,851,198			10
10a	Therapy			264	264		264		264			10a
11	Activities	123,815		10,553	134,368		134,368		134,368			11
12	Social Services	210,382		1,575	211,957		211,957	(2,623)	209,334			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,055,182	59,494	95,111	3,209,787		3,209,787	(2,623)	3,207,164			16
	C. General Administration											
17	Administrative	105,531		415,779	521,310		521,310	(415,779)	105,531			17
18	Directors Fees											18
19	Professional Services			49,164	49,164		49,164	(5,717)	43,447			19
20	Dues, Fees, Subscriptions & Promotions			31,087	31,087		31,087	(2,089)	28,998			20
21	Clerical & General Office Expenses	201,753	63,207	264,168	529,128		529,128	265,928	795,056			21
22	Employee Benefits & Payroll Taxes			1,040,930	1,040,930		1,040,930		1,040,930			22
23	Inservice Training & Education											23
24	Travel and Seminar			20,437	20,437		20,437		20,437			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			142,779	142,779		142,779		142,779			26
27	Other (specify):*											27
28	TOTAL General Administration	307,284	63,207	1,964,344	2,334,835		2,334,835	(157,657)	2,177,178			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,104,383	450,245	2,431,346	6,985,974		6,985,974	(178,424)	6,807,550			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			688,628	688,628		688,628	(118,043)	570,585			30
31	Amortization of Pre-Op. & Org.			31,759	31,759		31,759		31,759			31
32	Interest			738,053	738,053		738,053	(77,922)	660,131			32
33	Real Estate Taxes					#REF!	#REF!		#REF!			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,571	17,571		17,571		17,571			35
36	Other (specify):*											36
37	TOTAL Ownership			1,476,011	1,476,011	#REF!	#REF!	(195,965)	#REF!			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		179,480	417,432	596,912		596,912		596,912			39
40	Barber and Beauty Shops			27,809	27,809		27,809		27,809			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			179,913	179,913		179,913		179,913			42
43	Other (specify):*	16,866			16,866		16,866		16,866			43
44	TOTAL Special Cost Centers	16,866	179,480	625,154	821,500		821,500		821,500			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,121,249	629,725	4,532,511	9,283,485	#REF!	#REF!	(374,389)	#REF!			45

#REF!

*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	(2,874)	02		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	(118,043)	30		9
10	Interest and Other Investment Income	(77,922)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		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	(1,735)	21		24
25	Fund Raising, Advertising and Promotional	(2,089)	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	(24,124)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (226,787)		\$	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)	(147,602)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (147,602)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (374,389)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation Revenue	\$ (2,623)	12	1
2	Guest Apartment Revenue	(1,465)	06	2
3	Garage Revenue	(700)	06	3
4	Other Operating Revenue	(68)	21	4
5	Transfer Temp Rester For Oper	(446)	21	5
6	Dining Services Procurement Rebates	(13,105)	01	6
7	Legal Services - Adj	(5,717)	19	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	(24,124)		49

Summary A

01/31/12

[illegible]

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(118,043)											(118,043)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(77,922)											(77,922)	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	(195,965)											(195,965)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(226,787)	(147,602)										(374,389)	45

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
Covenant Retirement Communities	100%	See Page 6-Supp				
See Supplemental for related party information						

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	17	Management Service Fees	\$ 415,779	Covenant Retirement Communities		\$	(415,779)	1
2	V	21	IS Service Fees Software	46,324	Covenant Retirement Communities			(46,324)	2
3	V	21	Other Operating Expense	43,038	Covenant Retirement Communities			(43,038)	3
4	V	21	Centralized Billing - CRC	53,907	Covenant Retirement Communities			(53,907)	4
5	V	21	Office Expense - CRC Allocation		Covenant Retirement Communities		411,446	411,446	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 559,048			\$ 411,446	\$ * (147,602)	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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* 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			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	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	Curtis B. Anderson	BOD	Covenant Village Care Center - Florida	Plantation, FL				1
2	Rev. Richard B. Berry	BOD	Brandel Care Center	Northbrook, IL				2
3	Dan Danielson	BOD	Windsor Park Manor	Carol Stream, IL				3
4	James Elving	BOD	Covenant Village Care Center - Turlock	Turlock, CA				4
5	Marc Espinosa	BOD	Mount Miguel Covenant Village	Spring Valley, CA				5
6	Lorene Flewellen	BOD	Samarkand Skilled Nursing	Santa Barbara, CA				6
7	Beverly A. Freeman	BOD	Colonial Acres Care Center	Golden Valley, MN				7
8	Rhoda Friesen	BOD	Covenant Vilage of the Great Lakes	Grand Rapids, MI				8
9	Mary Miller	BOD	Covenant Village of Colorado	Westminster, CO				9
10	Cletus Moll	BOD	Pilgrim Manor	Cromwell, CT				10
11	Joyce Peterson	BOD	Covenant Shores	Mercer Island, WA				11
12	Norton Richards	BOD						12
13	Walter L. Schiller	BOD						13
14	Jean Stebinger	BOD						14
15	Anne Vining	BOD						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	See PG6-SUPP								\$		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 Covenant Health Care Center - Batavia # 0025577 Report Period Beginning: 02/01/11 Ending: 01/31/12

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 Covenant Retirement Communities
Street Address 5700 Old Orchard Road
City / State / Zip Code Skokie, IL 60077
Phone Number (773)878-2294
Fax Number (773) 878-2289

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	21	Office Expense - CRC Allocation	Total Expense			\$	\$		\$ 411,446	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					\$	\$		\$ 411,446	25

Facility Name & ID Number Covenant Health Care Center - Batavia # 0025577 Report Period Beginning: 02/01/11 Ending: 01/31/12

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
Street Address
City / State / Zip Code
Phone Number
Fax Number

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

Facility Name & ID Number Covenant Health Care Center - Batavia # 0025577 Report Period Beginning: 02/01/11 Ending: 01/31/12

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
Street Address
City / State / Zip Code
Phone Number
Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			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					\$	\$		\$	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	1998 ILL Rev Refund TE Bonds		X	Refinance Debt		1998	\$	718,852	2015	0.0410	\$ 36,841	1
2	2001 ILL TE Bonds		X	Building Construction		2001		8,758,200	2031	0.0588	514,544	2
3	2002A ILL TX Rev Bonds		X	Refinance Debt		2002		3,176,497	2028	0.0613	186,668	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	12,653,549			\$ 738,053	9
	B. Non-Facility Related*											
10	Interest Income		X								(77,922)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$ (77,922)	14
15	TOTALS (line 9+line14)						\$	12,653,549			\$ 660,131	15

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

* 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 2011 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 2012 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:		2007		8	
		2008		9	
		2009		10	
		2010		11	
		2011		12	
N/A - Facility does not pay real estate taxes due to its not-for-profit status					

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	\$	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.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Covenant Health Care Center - Batavia

COUNTY

Kane

FACILITY IDPH LICENSE NUMBER

0025577

CONTACT PERSON REGARDING THIS REPORT

Andrew B. Cutler

TELEPHONE

(847) 374-0400

FAX #:

(847) 374-0420

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 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 2011.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. N/A		\$	\$
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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,884 B. General Construction Type: Exterior Masonry Brick 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).

Ekstam - Assisted Living 62 Units

The Holmstad- Residential Living 275 Units

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: 224,930 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 31,759 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	Facility		1980	\$ 85,758	1
2					2
3	TOTALS			\$ 85,758	3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	99		1980	1980	\$ 2,546,788	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1982		4,706		20			4,706	9
10	Various		1983		16,662		20			16,662	10
11	Various		1984		832		20			832	11
12	Various		1986		14,644		20			14,644	12
13	Various		1987		12,021		20			12,021	13
14	Various		1988		9,128		20			9,128	14
15	Various		1989		15,226		20			15,226	15
16	Various		1990		40,083		20			40,083	16
17	Various		1991		18,354		20			18,354	17
18	Various		1992		18,931		20			18,931	18
19	Various		1993		90,076		20	4,504	4,504	90,076	19
20	Various		1994		56,935		20	2,847	2,847	54,088	20
21	Various		1995		84,370		20	4,219	4,219	75,933	21
22	Various		1996		9,674		20	484	484	8,223	22
23	Various		1997		4,570		20	229	229	3,656	23
24	Various		1998		5,750		20	288	288	4,313	24
25	Various		1999		5,092		20	255	255	3,564	25
26	Various		2000		9,810		20	491	491	6,377	26
27	Various		2002		1,541		20	77	77	848	27
28	Various		2004		8,747,969		20	437,398	437,398	3,936,586	28
29	Various		2005		20,996		20	1,050	1,050	8,398	29
30	Various		2008		126,294		20	6,315	6,315	31,574	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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	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								70
Related Building Company (Pages 12F & 12G)								
Related Party Allocations (Pages 12H & 12I)								
Financial Statement Depreciation			688,628			(688,628)		
TOTAL (lines 4 thru 69)		\$ 11,860,452	\$ 688,628		\$ 458,154	\$ (230,474)	\$ 4,374,222	

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

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 11,860,452	\$ 688,628		\$ 458,154	\$ (230,474)	\$ 4,374,222	1
2 Furnace	2009	8,719		20	436	436	1,744	2
3 Water Heater	2009	2,684		20	134	134	537	3
4 Nurse Call System	2009	7,906		20	395	395	1,581	4
5 Doors	2009	20,411		20	1,021	1,021	4,082	5
6 Doors	2009	2,775		20	139	139	555	6
7 Sidewalk	2009	2,575		20	129	129	515	7
8 Drainage Area	2009	11,380		20	569	569	2,276	8
9 Lighting Improvement	2010	18,500		20	925	925	2,775	9
10 Lighting Improvement	2010	22,280		20	1,114	1,114	3,342	10
11 Automatic Trash Doors	2010	5,077		20	254	254	762	11
12 Therapy Heater	2010	4,273		20	214	214	641	12
13 Safety Barrier	2010	15,000		20	750	750	2,250	13
14 Vertical Shaft	2010	28,360		20	1,418	1,418	4,254	14
15 237 Cabinets	2010	3,356		20	168	168	503	15
16 Mhc Chiller Repair	2010	3,642		20	182	182	546	16
17 Mhc Compressor Repair	2010	4,483		20	224	224	672	17
18 Mhc Chiller Repair	2010	2,919		20	146	146	438	18
19 Mhc Soil Application	2010	6,584		20	329	329	988	19
20 Ccs Painting	2010	2,868		20	143	143	430	20
21 Hobart Disposer	2011	3,555		20	18	18	18	21
22 2Nd Floor Mhc Shower	2011	5,886		20	29	29	29	22
23 Mhc - Walk- In Freezer	2011	79,330		20	3,967	3,967	3,967	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 12,123,016	\$ 688,628		\$ 470,857	\$ (217,771)	\$ 4,407,127	34

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

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	
1	Totals from Page 12B, Carried Forward		\$12,123,016	\$688,628		\$470,857	\$ (217,771)	\$4,407,127	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	TOTAL (lines 1 thru 33)		\$12,123,016	\$688,628		\$470,857	\$ (217,771)	\$4,407,127	34

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 12,123,016	\$ 688,628		\$ 470,857	\$ (217,771)	\$ 4,407,127	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	TOTAL (lines 1 thru 33)		\$ 12,123,016	\$ 688,628		\$ 470,857	\$ (217,771)	\$ 4,407,127	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 12,123,016	\$ 688,628		\$ 470,857	\$ (217,771)	\$ 4,407,127	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 TOTAL (lines 1 thru 33)		\$ 12,123,016	\$ 688,628		\$ 470,857	\$ (217,771)	\$ 4,407,127	34

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

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	
1	Building Company Information		\$	\$		\$	\$	\$	1
2	Buildings:								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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

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	
1	Totals from Page 12F, Carried Forward		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)
B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party Information		\$	\$		\$	\$	\$	1
2 Buildings:								2
3								3
4								4
5								5
6								6
7								7
8 Leasehold Improvements:								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 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party Information Continued		\$	\$		\$	\$	\$	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 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**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	\$946,248	\$	\$95,761	\$95,761	10	\$563,960	71
72	Current Year Purchases	15,780		1,578	1,578	10	1,578	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$962,028	\$	\$97,339	\$97,339		\$565,538	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	Facility	2008 Ford E-150 Wheelchair Van	2007	\$11,944	\$	\$2,389	\$2,389	5	\$11,944	76
77										77
78										78
79										79
80	TOTALS			\$11,944	\$	\$2,389	\$2,389		\$11,944	80

E. Summary of Care-Related Assets

	1	2	
	Reference	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)	\$13,182,745	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$688,628	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$570,585	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(118,043)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$4,984,609	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: N/A
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: \$ 17,571
- Description: See attached schedule
- (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. /2013 \$

13. /2014 \$

14. /2015 \$

* 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

ALLOCATION OF COSTS (d)

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

		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)	\$			

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.)

12345678										
	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	39 - 03	hrs	\$		\$ 19,854	\$		\$ 19,854	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			136,894			136,894	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			237,408			237,408	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				108,462		108,462	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental					23,276	71,018		94,294	13
14	TOTAL			\$		\$ 417,432	\$ 179,480		\$ 596,912	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits	3,045		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	713,723		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	15,246		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	243,029		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 975,193	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	85,758		13
14	Buildings, at Historical Cost	11,807,411		14
15	Leasehold Improvements, at Historical Cost	14,190		15
16	Equipment, at Historical Cost	1,143,720		16
17	Accumulated Depreciation (book methods)	(7,791,412)		17
18	Deferred Charges	325,646		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Supplemental Schedule</u>	7,104,437		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,689,750	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,664,943	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 132,417	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	305,337		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,496		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	246,210		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Supplemental Schedule</u>	45,693		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 739,153	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	12,653,549		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>See Supplemental Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,653,549	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 13,392,702	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 272,241	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,664,943	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 338,254	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 338,254	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(66,013)	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)	\$ (66,013)	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)	\$ 272,241	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Covenant Health Care Center - Batavia

0025577

Report Period Beginning: 02/01/11

Ending: 01/31/12

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	\$ 9,121,545	1
2	Discounts and Allowances for all Levels	(1,344,474)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,777,071	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	696,408	6
7	Oxygen	19,792	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 716,200	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	36,737	13
14	Non-Patient Meals	2,874	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,165	16
17	Sale of Drugs	118,125	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,985	19
20	Radiology and X-Ray		20
21	Other Medical Services	154,769	21
22	Laundry	56,350	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 391,005	23
	D. Non-Operating Revenue		
24	Contributions	2,075	24
25	Interest and Other Investment Income***	328,949	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 331,024	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	2,172	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,172	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,217,472	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,441,352	31
32	Health Care	3,209,787	32
33	General Administration	2,334,835	33
	B. Capital Expense		
34	Ownership	1,476,011	34
	C. Ancillary Expense		
35	Special Cost Centers	641,587	35
36	Provider Participation Fee	179,913	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,283,485	40
41	Income before Income Taxes (line 30 minus line 40)**	(66,013)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (66,013)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 2,126,779	44
45	Private Pay - Net Inpatient Revenue	5,873,444	45
46	Medicare - Net Inpatient Revenue	1,106,758	46
47	Other-(specify) <u>Managed Care</u>	14,564	47
48	Other-(specify) <u>Contractual Allowances/Discounts</u>	(1,344,474)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,777,071	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? N/A 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	1,816	2,080	\$ 93,682	\$ 45.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,230	36,527	1,155,114	31.62	3
4	Licensed Practical Nurses	7,831	8,964	217,095	24.22	4
5	CNAs & Orderlies	75,983	84,238	1,224,326	14.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,700	1,928	24,186	12.54	9
10	Activity Assistants	6,350	6,978	99,629	14.28	10
11	Social Service Workers	7,388	8,155	210,382	25.80	11
12	Dietician					12
13	Food Service Supervisor	2,730	3,078	57,174	18.58	13
14	Head Cook	5,975	6,473	99,489	15.37	14
15	Cook Helpers/Assistants	16,015	16,862	186,137	11.04	15
16	Dishwashers					16
17	Maintenance Workers	10,685	11,715	212,449	18.13	17
18	Housekeepers	10,606	11,684	131,242	11.23	18
19	Laundry	3,817	4,237	55,426	13.08	19
20	Administrator	1,864	2,232	105,531	47.28	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,405	10,433	201,753	19.34	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	1,387	1,567	30,768	19.63	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	#REF!	941	16,866	17.92	33
34	TOTAL (lines 1 - 33)	#REF!	218,092	\$ 4,121,249 *	\$ 18.90	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	Monthly	\$ 67,283	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Monthly	1,195	10-03	37
38	Nurse Consultant	Variable	69,524	10-03	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	4	264	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		10,553	11-03	44
45	Social Service Consultant		1,575	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4	\$ 162,394		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.

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		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

(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.

Covenant Health Care Center - Batavia
0025577
Page 21 Legal
2/1/11-1/31/12

4180-6121	
Vendor	Balance
Polsinelli Shughart	3,895.00
Polsinelli Shughart	1,150.00
Corporation Service Company	78.12
Legal Expense - recurring JE	5,208.36
Illinois Charity Bureau Fund	280.00
James E. McParland, Atty	105.00
	10,716.48
P5A Adj	(5,717.00)
Adjusted Total	4,999.48

Covenant Health Care Center - Batavia
Fixed Asset Capital Report Reconciliation
2/1/2011-1/31/2012

Total Assets per 6/30/2010 Capital Report 11,982,032

2010 Assets AddedAfter Capital report	
Vertical Shaft	28,360
237 Cabinets	3,356
MHC Chiller Repair	3,642
MHC Compressor Repair	4,483
MHC Chiller Repair	2,919
MHC Soil Application	6,584
CCS Paintings	2,868
Total 2010 Additions	<u>52,212</u>

2011 Assets Added after Capital Report	
Hobart Disposer	3,555
2nd Floor MHC Shower	5,886
MHC Walk In Freezer	<u>79,330</u>
Total 2011 Additions	<u>88,771</u>

Total Assets Page 12 - 1/31/2012 CR	<u>12,123,015</u>
--	--------------------------