

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 N/A

	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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	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	9,727	6,565	15,604	31,896	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,727	6,565	15,604	31,896	14

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

ACCRUAL 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				Reclassification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(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

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(147,602)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (147,602)		36
	(sum of SUBTOTALS			
37	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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	

Covenant Health Care Center - Batavia

ID# 0025577

Report Period Beginning: 02/01/11

Ending: 01/31/12

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

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Health Care Center - Batavia# 0025577

Report Period Beginning:

02/01/11

Ending:

01/31/12**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	(13,105)											(13,105)	1
2	Food Purchase	(2,874)											(2,874)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(2,165)											(2,165)	6
7	Other (specify):*													7
8	TOTAL General Services	(18,144)											(18,144)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services	(2,623)											(2,623)	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(2,623)											(2,623)	16
	C. General Administration													
17	Administrative		(415,779)										(415,779)	17
18	Directors Fees													18
19	Professional Services	(5,717)											(5,717)	19
20	Fees, Subscriptions & Promotions	(2,089)											(2,089)	20
21	Clerical & General Office Expenses	(2,249)	268,177										265,928	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	TOTAL General Administration	(10,055)	(147,602)										(157,657)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(30,822)	(147,602)										(178,424)	29

STATE OF ILLINOIS

Facility Name & ID Number Covenant Health Care Center - Batavia

0025577

Report Period Beginning:

02/01/11

Ending:

Summary B

01/31/12

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
<u>Covenant Retirement Communities</u>	<u>100%</u>	<u>See Page 6-Supp</u>				
<u>See Supplemental for related party information</u>						

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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	<u>17 Management Service Fees</u>	<u>\$ 415,779</u>	<u>Covenant Retirement Communities</u>		\$		<u>(415,779)</u> 1
2	V	<u>21 IS Service Fees Software</u>	<u>46,324</u>	<u>Covenant Retirement Communities</u>				<u>(46,324)</u> 2
3	V	<u>21 Other Operating Expense</u>	<u>43,038</u>	<u>Covenant Retirement Communities</u>				<u>(43,038)</u> 3
4	V	<u>21 Centralized Billing - CRC</u>	<u>53,907</u>	<u>Covenant Retirement Communities</u>				<u>(53,907)</u> 4
5	V	<u>21 Office Expense - CRC Allocation</u>		<u>Covenant Retirement Communities</u>		<u>411,446</u>		<u>411,446</u> 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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	\$ *

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

Facility Name & ID Number

Covenant Health Care Center - Batavia

0025577

Report Period Beginning:

02/01/11

Ending:

01/31/12

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

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

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

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

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.)

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1980</u>	<u>\$ 85,758</u>	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	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	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					688,628		(688,628)	69
70		\$ 11,860,452	\$ 688,628		\$ 458,154	\$ (230,474)	\$ 4,374,222	70

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

Facility Name & ID Number Covenant Health Care Center - Batavia

0025577

Report Period Beginning:

02/01/11

Ending:

01/31/12

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	
	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	Improvement Type**	3	4	5	6	7	8	9	
		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	Improvement Type**	3	4	5	6	7	8	9	
		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	4	Cost	5	Current Book	6	Life	7	Straight Line	8	Adjustments	9	Accumulated	
			Constructed				Depreciation		in Years		Depreciation				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	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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
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	4	5	6	7	8	9	
		Year	Cost	Current Book	Life	Straight Line	Adjustments	Accumulated	
		Constructed		Depreciation	in Years	Depreciation		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		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
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 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)	\$ 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.)

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

1	Service	Schedule V Line & Column Reference	2 Staff		3		4 Outside Practitioner (other than consultant)		5	6	7	8		
			Units of Service	Cost	Units	Cost	Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)					
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): <u>See Supplemental</u>						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.

Facility Name & ID Number Covenant Health Care Center - Batavia

0025577

Report Period Beginning: 02/01/11

Ending:

01/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/12

(last day of reporting year)

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.

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	See Supplemental Schedule	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.

Facility Name & ID Number Covenant Health Care Center - Batavia

0025577

Report Period Beginning:

02/01/11

Ending:

01/31/12

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

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	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

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

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. LSN and AAHSA - \$5713
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 55,411 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 179,913
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. \$ Yes Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,874
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Line 14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. **Does the facility transport residents to and from day training? N/A**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Deloitte
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Covenant Health Care Center - Batavia

0025577

Page 21 Legal

2/1/11-1/31/12

4180-6121

<u>Vendor</u>	<u>Balance</u>
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	<u>(5,717.00)</u>
Adjusted Total	<u>4,999.48</u>

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 Added After 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	79,330
Total 2011 Additions	<u>88,771</u>

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