

Facility Name & ID Number Covenant HCC-Batavia

0025577 Report Period Beginning: 02/01/12 Ending: 01/31/13

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	8,657	15,899	5,818	30,374	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,657	15,899	5,818	30,374	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.06%

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 5,021

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 HCC-Batavia # 0025577 Report Period Beginning: 02/01/12 Ending: 01/31/13

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	365,721	44,944	65,113	475,778	475,778	(16,872)	458,906			1
2	Food Purchase		257,691		257,691	257,691	(2,710)	254,981			2
3	Housekeeping	115,872	31,679	31	147,582	147,582		147,582			3
4	Laundry	56,131	5,434	28,992	90,557	90,557		90,557			4
5	Heat and Other Utilities			158,065	158,065	158,065		158,065			5
6	Maintenance	199,503	6,873	147,919	354,295	354,295	(1,982)	352,313			6
7	Other (specify):*										7
8	TOTAL General Services	737,227	346,621	400,120	1,483,968	1,483,968	(21,564)	1,462,404			8
	B. Health Care and Programs										
9	Medical Director			12,000	12,000	12,000		12,000			9
10	Nursing and Medical Records	2,666,237	50,685	147,316	2,864,238	2,864,238		2,864,238			10
10a	Therapy										10a
11	Activities	125,517	13,764	4,442	143,723	143,723		143,723			11
12	Social Services	180,407	124	1,622	182,153	182,153	(2,769)	179,384			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,972,161	64,573	165,380	3,202,114	3,202,114	(2,769)	3,199,345			16
	C. General Administration										
17	Administrative	94,146		426,061	520,207	520,207	(426,061)	94,146			17
18	Directors Fees										18
19	Professional Services			36,131	36,131	36,131	(5,957)	30,174			19
20	Dues, Fees, Subscriptions & Promotions			40,913	40,913	40,913	(3,743)	37,170			20
21	Clerical & General Office Expenses	183,653	29,842	306,650	520,145	520,145	389,286	909,431			21
22	Employee Benefits & Payroll Taxes			1,105,645	1,105,645	1,105,645	(4,749)	1,100,896			22
23	Inservice Training & Education										23
24	Travel and Seminar			36,858	36,858	36,858	(23)	36,835			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			131,893	131,893	131,893		131,893			26
27	Other (specify):*										27
28	TOTAL General Administration	277,799	29,842	2,084,151	2,391,792	2,391,792	(51,247)	2,340,545			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,987,187	441,036	2,649,651	7,077,874	7,077,874	(75,580)	7,002,294			29

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

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

Facility Name & ID Number

Covenant HCC-Batavia

#0025577

Report Period Beginning:

02/01/12

Ending:

01/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			705,104	705,104		705,104	(121,255)	583,849			30
31	Amortization of Pre-Op. & Org.			27,542	27,542		27,542		27,542			31
32	Interest			688,846	688,846		688,846	(61,072)	627,774			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,805	17,805		17,805		17,805			35
36	Other (specify):*											36
37	TOTAL Ownership			1,439,297	1,439,297		1,439,297	(182,327)	1,256,970			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		212,310	542,360	754,670		754,670		754,670			39
40	Barber and Beauty Shops		360	24,703	25,063		25,063		25,063			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			224,896	224,896		224,896		224,896			42
43	Other (specify):*	14,161			14,161		14,161	(14,161)				43
44	TOTAL Special Cost Centers	14,161	212,670	791,959	1,018,790		1,018,790	(14,161)	1,004,629			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,001,348	653,706	4,880,907	9,535,961		9,535,961	(272,068)	9,263,893			45

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

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		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	(2,710)	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	(121,255)	30		9
10	Interest and Other Investment Income	(61,072)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(13,022)	21		24
25	Fund Raising, Advertising and Promotional	(3,743)	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	(53,030)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (254,832)		\$	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)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (254,832)		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
						52

Covenant HCC-Batavia

ID# 0025577

Report Period Beginning: 02/01/12

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NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Transportation Revenue	\$ (2,769)	12	1
2	Transfer Temp Restr For Oper	(815)	21	2
3	Telephone Revenue	(12)	21	3
4	Guest Apartment Revenue	(1,395)	06	4
5	Garage Revenue	(587)	06	5
6	Other Operating Income	(82)	21	6
7	Inter-campus Revenue	(5,088)	21	7
8	Procurement Rebates	(16,872)	01	8
9	Fundraising - Administrative	(520)	21	9
10	Fundraising - Employee Benefits	(4,749)	22	10
11	Fundraising - Salary	(14,161)	43	11
12	Fundraising - Travel	(23)	24	12
13	Legal Services - Adj	(5,957)	19	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	(53,030)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant HCC-Batavia# 0025577

Report Period Beginning:

02/01/12

Ending:

01/31/13**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(16,872)	0	0	0	0	0	0	0	0	0	0	(16,872)	1
2	Food Purchase	(2,710)	0	0	0	0	0	0	0	0	0	0	(2,710)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,982)	0	0	0	0	0	0	0	0	0	0	(1,982)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21,564)	0	0	0	0	0	0	0	0	0	0	(21,564)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(2,769)	0	0	0	0	0	0	0	0	0	0	(2,769)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(2,769)	0	0	0	0	0	0	0	0	0	0	(2,769)	16
	C. General Administration													
17	Administrative	0	(426,061)	0	0	0	0	0	0	0	0	0	(426,061)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,957)	0	0	0	0	0	0	0	0	0	0	(5,957)	19
20	Fees, Subscriptions & Promotions	(3,743)	0	0	0	0	0	0	0	0	0	0	(3,743)	20
21	Clerical & General Office Expenses	(19,539)	408,825	0	0	0	0	0	0	0	0	0	389,286	21
22	Employee Benefits & Payroll Taxes	(4,749)	0	0	0	0	0	0	0	0	0	0	(4,749)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(23)	0	0	0	0	0	0	0	0	0	0	(23)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(34,011)	(17,236)	0	(51,247)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(58,344)	(17,236)	0	(75,580)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant HCC-Batavia# 0025577

Report Period Beginning:

02/01/12

Ending:

01/31/13

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	(121,255)	0	0	0	0	0	0	0	0	0	0	(121,255) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(61,072)	0	0	0	0	0	0	0	0	0	0	(61,072) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(182,327)	0	0	0	0	0	0	0	0	0	0	(182,327) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(14,161)	0	0	0	0	0	0	0	0	0	0	(14,161) 43
44	TOTAL Special Cost Centers	(14,161)	0	0	0	0	0	0	0	0	0	0	(14,161) 44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(254,832)	(17,236)	0	(272,068) 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>				

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 Fees</u>	\$ <u>426,061</u>	<u>Covenant Retirement Communities</u>		\$	\$ <u>(426,061)</u>	1
2	V	<u>21 IS Licensing Fees</u>	<u>82,072</u>	<u>Covenant Retirement Communities</u>			<u>(82,072)</u>	2
3	V	<u>21 Other Operating Expense</u>	<u>169,446</u>	<u>Covenant Retirement Communities</u>			<u>(169,446)</u>	3
4	V	<u>21 Office Expense - CRC Allocation</u>		<u>Covenant Retirement Communities</u>		<u>660,343</u>	<u>660,343</u>	4
5	V							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		\$ <u>677,579</u>			\$ <u>660,343</u>	\$ * <u>(17,236)</u>	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Jon P. Aagaard, M.D.	BOD	Covenant Village Care Center - Florida	Plantation, FL				2
3	Rev. Richard B. Berry	BOD	Brandel Care Center	Northbrook, IL				3
4	Pamela Christensen	BOD	Windsor Park Manor	Carol Stream, IL				4
5	Rev. Harvey Drake	BOD	Covenant Village Care Center - Turlock	Turlock, CA				5
6	Mark Eastburg	BOD	Mount Miguel Covenant Village	Spring Valley, CA				6
7	James Elving	BOD	Samarkand Skilled Nursing	Santa Barbara, CA				7
8	Marc Espinosa	BOD	Colonial Acres Care Center	Golden Valley, MN				8
9	Carol A. Findling	BOD	Covenant Vilage of the Great Lakes	Grand Rapids, MI				9
10	Lorene G. Flewellen	BOD	Covenant Village of Colorado	Westminster, CO				10
11	Rhonda Friesen	BOD	Pilgrim Manor	Cromwell, CT				11
12	Thomas F. Heywood	BOD	Covenant Shores	Mercer Island, WA				12
13	Donald Hodgkinson	BOD						13
14	Jody Holt	BOD						14
15	Cletus J. Moll	BOD						15
16	Nortob Richards	BOD						16
17	Marlene E. Stante	BOD						17
18	Anne E. Vining	BOD						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 HCC-Batavia

0025577

Report Period Beginning:

02/01/12

Ending:

01/31/13

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 HCC-Batavia

0025577

Report Period Beginning:

02/01/12

Ending: 01/31/13

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Office Expense - CRC Allocation	Total Expense		\$	\$		\$ 660,343	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				\$	\$		\$ 660,343	25

Facility Name & ID Number

Covenant HCC-Batavia

0025577

Report Period Beginning:

02/01/12

Ending:

01/31/13

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	2011B ILL TX Bonds		X	Refinance Debt			\$	\$ 265,224		\$ 3,499	1									
2	2012A CO TX Bonds		X	Refinance Debt				10,133,505		202,485	2									
3	2012C CO TX Bonds		X	Refinance Debt				2,644,002		44,793	3									
4	1998/2001/2002 ILL TX Bonds		X	Refinance Debt/Building Construction					Var	Var	438,071	4								
5											5									
Working Capital																				
6											6									
7											7									
8											8									
9	TOTAL Facility Related						\$	\$ 13,042,731		\$ 688,848	9									
B. Non-Facility Related*																				
10	Interest Income									(61,072)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (61,072)	14									
15	TOTALS (line 9+line14)						\$	\$ 13,042,731		\$ 627,776	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

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																
1. Real Estate Tax accrual used on 2012 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 2013 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:	<table border="1"> <tr><td>2008</td><td>_____</td><td>8</td></tr> <tr><td>2009</td><td>_____</td><td>9</td></tr> <tr><td>2010</td><td>_____</td><td>10</td></tr> <tr><td>2011</td><td>_____</td><td>11</td></tr> <tr><td>2012</td><td>_____</td><td>12</td></tr> </table>	2008	_____	8	2009	_____	9	2010	_____	10	2011	_____	11	2012	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2012 \$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5 \$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6 \$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION \$</td><td>16</td></tr> </table>	FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2012 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
2008	_____	8																														
2009	_____	9																														
2010	_____	10																														
2011	_____	11																														
2012	_____	12																														
FOR BHF USE ONLY																																
13	FROM R. E. TAX STATEMENT FOR 2012 \$	13																														
14	PLUS APPEAL COST FROM LINE 5 \$	14																														
15	LESS REFUND FROM LINE 6 \$	15																														
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																														
N/A - Facility does not pay real estate taxes due to its not-for-profit status.																																

NOTES:

- Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.**
- 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.**

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: _____ 2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	<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
Bed* 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	\$		\$	\$	\$
5								
6								
7								
8								
Improvement Type**								
9 Various		1982	4,706		20			4,706
10 Various		1983	16,662		20			16,662
11 Various		1984	832		20			832
12 Various		1986	14,644		20			14,644
13 Various		1987	12,021		20			12,021
14 Various		1988	9,128		20			9,128
15 Various		1989	15,226		20			15,226
16 Various		1990	40,083		20			40,083
17 Various		1991	18,354		20			18,354
18 Various		1992	18,931		20			19,831
19 Various		1993	90,076		20			90,076
20 Various		1994	56,935		20	2,847	2,847	56,935
21 Various		1995	84,370		20	4,219	4,219	80,152
22 Various		1996	9,674		20	484	484	8,707
23 Various		1997	4,570		20	229	229	3,885
24 Various		1998	5,750		20	288	288	4,601
25 Various		1999	5,092		20	255	255	3,819
26 Various		2000	9,810		20	491	491	6,868
27 Various		2001	1,541		20	77	77	925
28 Various		2004	8,747,969		20	437,398	437,398	4,373,984
29 Various		2005	20,996		20	1,050	1,050	9,448
30 Various		2008	126,294		20	6,315	6,315	37,889
31 Various		2009	56,450		20	2,823	2,823	14,113
32								
33								
34								
35								
36								

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**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	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Lighting Improvement	2010	\$ 18,500	\$	20	\$ 925	\$ 925	\$ 3,700	37
38	Lighting Improvement	2010	22,280		20	1,114	1,114	4,456	38
39	Automatic Trash Doors	2010	5,077		20	254	254	1,016	39
40	Therapy Heater	2010	4,273		20	214	214	856	40
41	Safety Barrier	2010	15,000		20	750	750	3,000	41
42	Vertical Shaft	2010	28,360		20	1,418	1,418	5,672	42
43	237 Cabinets	2010	3,356		20	168	168	672	43
44	Mhc Chiller Repair	2010	3,642		20	182	182	728	44
45	Mhc Compressor Repair	2010	4,483		20	224	224	896	45
46	Mhc Chiller Repair	2010	2,919		20	146	146	584	46
47	Mhc Soil Application	2010	6,584		20	329	329	1,316	47
48	Ccs Painting	2010	2,868		20	143	143	572	48
49	Hobart Disposer	2011	3,555		20	178	178	196	49
50	2Nd Floor Mhc Shower	2011	5,886		20	294	294	323	50
51	Mhc - Walk- In Freezer	2011	79,330		20	3,967	3,967	7,934	51
52	Courtyard Door Latch	2012	2,921		20	146	146	146	52
53	MHC South Exit Door	2012	5,286		20	264	264	264	53
54	MHC 2nd Fl. Corridor Remodel- Flooring, Wall Finishes/Paint,								54
55	Electrical Fixtures	2012	49,081		20	2,454	2,454	2,454	55
56	Remodel 11 Mulberry Rooms - Flooring, Plumbing, Structural /Walls,								56
57	Wall Finishes/Paint, Window Coverings, Electrical Fixtures	2012	99,032		20	4,951	4,951	4,951	57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)								68
69	Financial Statement Depreciation			705,104			(705,104)		69
70	TOTAL (lines 4 thru 69)		\$ 12,279,336	\$ 705,104		\$ 474,597	\$ (230,507)	\$ 4,882,625	70

**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	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 12H, Carried Forward	\$ 12,279,336	\$ 705,104		\$ 474,597	\$ (230,507)	\$ 4,882,625		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)	\$ 12,279,336	\$ 705,104		\$ 474,597	\$ (230,507)	\$ 4,882,625		34

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

Facility Name & ID Number Covenant HCC-Batavia

0025577

Report Period Beginning:

02/01/12

Ending:

01/31/13

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	\$ 962,028	\$	\$ 97,339	\$ 97,339	10	\$ 662,877	71
72	Current Year Purchases	133,683		9,524	9,524	10	9,524	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,095,711	\$	\$ 106,863	\$ 106,863		\$ 672,401	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 Va	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)	\$ 13,472,749	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 705,104	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 583,849	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (121,255)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,566,970	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Covenant HCC-Batavia

0025577

Report Period Beginning: 02/01/12

Ending: 01/31/13

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: \$ 17,805 Description: See Attached

(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.	_____ /2014	\$ _____
13.	_____ /2015	\$ _____
14.	_____ /2016	\$ _____

* 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.

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<u>Description</u>	<u>Amount</u>
Copier	17622
Postage Machine	183
	<u>17805</u>

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		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.)

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ 280,280	\$		\$ 280,280	1
2	Licensed Speech and Language Development Therapist		hrs			27,958			27,958	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			200,265			200,265	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				132,327		132,327	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					33,857	79,983		113,840	13
14	TOTAL			\$		\$ 542,360	\$ 212,310		\$ 754,670	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.

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Special Services - Supplies (Column 6 - Other)	Amount
Nursing & Med Supp	74,184
Equipment Rental/Repairs	5,799

79,983

Special Services - Outside (Column 5 - Other)	Amount
Laboratory and X-Ray (Lax) Exp	28,167
Oxygen (Oxy) Expense	5,690

33,857

Special Services - Outside (Column 5 - Other)	Amount
--	---------------

Facility Name & ID Number Covenant HCC-Batavia

0025577

Report Period Beginning: 02/01/12

Ending:

01/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/13

(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	3,909		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,015,573		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,721		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Supplemental Schedule</u>	170,439		9
	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,203,792	\$	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	11,831,588		14
15	Leasehold Improvements, at Historical Cost	14,190		15
16	Equipment, at Historical Cost	1,020,803		16
17	Accumulated Depreciation (book methods)	(8,106,022)		17
18	Deferred Charges	204,305		18
19	Organization & Pre-Operating Costs			19
	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>	7,121,498		23
	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,172,120	\$	24
	TOTAL ASSETS (sum of lines 10 and 24)	\$ 13,375,912	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 173,898	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	360,443		29
30	Accrued Salaries Payable	264,916		30
	Accrued Taxes Payable (excluding real estate taxes)	45,573		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	102,806		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See supplemental schedule</u>	36,402		36
37	<u>Original Issue Premium (net)</u>	499,989		37
	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,484,027	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	12,682,288		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,682,288	\$	45
	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 14,166,315	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (790,403)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 13,375,912	\$	48

*(See instructions.)

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Other Current Assets:	<u>Amount</u>
Bond Sinking Fund	58,516
Bond Interest Fund	102,323
Acc Int Debt Service Reserves	9,600

170,439

Other Non-Current Assets:	<u>Amount</u>
Benevolent Care Fund	237,806
Property Replacement Fund	3,527
Capital Reserve Fund	80,153
Debt Service Reserve Fund	1,268,297
Asset Clearing	367
Original Issue Discount (OID), Net Admin - Zone 91	23,266
	<u>5,508,082</u>
	<u>7,121,498</u>

Other Current Liabilities:	<u>Amount</u>
Resident Trust Funds	3,909
Other Current Liabilities	30,296
Design Contributions-General	1,320
Design Contributions-Project 1	877

36,402

Other Non-Current Liabilities:	<u>Amount</u>
--------------------------------	---------------

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 272,239	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 272,241	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,062,641)	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)	\$ (1,062,641)	17
B. Transfers (Itemize):			
18			18
19	Rounding	(3)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (3)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (790,403)	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,003,570	1
2	Discounts and Allowances for all Levels	(1,542,286)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,461,284	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	904,608	6
7	Oxygen	26,978	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 931,586	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	33,909	13
14	Non-Patient Meals	2,710	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,982	16
17	Sale of Drugs	134,201	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	29,394	19
20	Radiology and X-Ray		20
21	Other Medical Services	144,452	21
22	Laundry	52,976	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 399,624	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	(327,984)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (327,984)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	8,810	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 8,810	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,473,320	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,483,968	31
32	Health Care	3,202,114	32
33	General Administration	2,391,792	33
B. Capital Expense			
34	Ownership	1,439,297	34
C. Ancillary Expense			
35	Special Cost Centers	793,894	35
36	Provider Participation Fee	224,896	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,535,961	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,062,641)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,062,641)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 2,293,087	44
45	Private Pay - Net Inpatient Revenue	5,237,283	45
46	Medicare - Net Inpatient Revenue	1,449,485	46
47	Other-(specify) <u>Managed Care</u>	23,715	47
48	Other-(specify) <u>Contractual Allowances/Discounts</u>	(1,542,286)	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,461,284	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.

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Description	Amount
Intercampus Revenue	5,088
Maintenance Services	44
Telephone Revenue	12
Transportation Revenue	2,769
Transfer Temp Restr For Oper	815
Other Operating Income	82

8,810

Facility Name & ID Number **Covenant HCC-Batavia**

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Report Period Beginning:

02/01/12

Ending:

01/31/13

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	1,264	1,457	\$ 55,754	\$ 38.27	1
2	Assistant Director of Nursing					2
3	Registered Nurses	34,602	38,275	1,239,058	32.37	3
4	Licensed Practical Nurses	6,861	7,456	192,181	25.78	4
5	CNAs & Orderlies	70,218	77,367	1,147,311	14.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,803	2,094	36,294	17.33	9
10	Activity Assistants	6,136	6,514	89,223	13.70	10
11	Social Service Workers	5,914	6,516	180,407	27.69	11
12	Dietician					12
13	Food Service Supervisor	2,843	3,174	60,211	18.97	13
14	Head Cook	7,311	7,810	119,967	15.36	14
15	Cook Helpers/Assistants	16,263	17,077	185,543	10.87	15
16	Dishwashers					16
17	Maintenance Workers	10,315	11,504	199,503	17.34	17
18	Housekeepers	9,673	10,499	115,872	11.04	18
19	Laundry	3,822	4,240	56,131	13.24	19
20	Administrator	1,569	1,880	94,146	50.08	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,317	9,057	183,653	20.28	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	1,420	1,578	31,933	20.24	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	697	757	14,161	18.71	33
34	TOTAL (lines 1 - 33)	189,028	207,255	\$ 4,001,348 *	\$ 19.31	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	\$ 65,113	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	30	1,492	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	33,414	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		4,442	11-03	44
45	Social Service Consultant		1,537	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	30	\$ 117,998		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

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	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Fundraising	697	757	13,879	18.33
Marketing			282	
	<u>697</u>	<u>757</u>	<u>14,161</u>	<u>18.33</u>

Covenant Health Care Center - Batavia

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<u>Account</u>	<u>Balance</u>
Legal Services	10,956.14
PG5A Adj	(5,957.00)
Adjusted Total	<u>4,999.14</u>

Covenant Health Care - Batavia
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Travel Schedule
02/01/12-01/31/13

Account Description	Account Number	Amount
Travel And Auto	4701	22,830.01
Travel And Auto	4701	741.71
Travel And Auto	4701	4,771.48
Travel And Auto	4701	2,156.77
		<u>30,499.97</u>

Payroll reimbursed Travel Detail

POSTING-DATE	DESCRIPTION	BASE-AMOUNT	ACCT-UNIT	Orig. Prgm	CURRENCY-CODE
10/31/2012	PR Dist PPE	22.53	4195	GL40	USD
11/30/2012	PR DIST PPE	60.50	4140	GL40	USD
11/30/2012	PR DIST PPE	72.73	4180	GL40	USD
11/30/2012	PR DIST PPE	227.86	4142	GL40	USD
		<u>383.62</u>			

Acct	Unit	APINVOICE.DESCRPTION	Date	Vendor Name	Amount	Employee	Employee Title	Event Name	Place of Event	Type of Expense
4701	4142	Reimburse for travel expense	02/29/2012	Sally Pierce	377.96	Sally Pierce	Chaplains	MidWinter Meeting	Chicago,IL	Travel to/from airport, meals
4701	4144	Gas for company vehicles	02/29/2012	Exxon Mobil Business Card	190.52	Drivers	Transportation	----	----	gas for company vehicles
4701	4144	Gas for company vehicles	03/31/2012	Exxon Mobil Business Card	176.96	Drivers	Transportation	----	----	gas for company vehicles
4701	4144	Gas for company vehicles	04/30/2012	Exxon Mobil Business Card	362.48	Drivers	Transportation	----	----	gas for company vehicles
4701	4142	Conference/travel expense	04/30/2012	Sally Pierce	135.89	Sally Pierce	Chaplains	Ministerium Conferer	Sheboygan, V	Gas, meals
4701	4144	Gas for company vehicles	09/30/2012	Exxon Mobil Business Card	329.66	Drivers	Transportation	----	----	gas for company vehicles
4701	4180	FIA credit cards	06/30/2012	FIA Card Services	67.92	Anna-Lisa Wh	Healthcatre Admin Asst.	LSN	Chicago,IL	Travel/Meal
4701	4144	Gas for company vehicles	09/30/2012	Exxon Mobil Business Card	453.73	Drivers	Transportation	----	----	gas for company vehicles
4701	4180	Reimburse for travel expense	07/31/2012	Marya Jordan	55.31	Marya Jordan	Healthcatre Admin.	Meeting/Saminar	Wheaton,IL	Gas, meals
4701	4144	Gas for company vehicles	09/30/2012	Exxon Mobil Business Card	419.75	Drivers	Transportation	----	----	gas for company vehicles
4701	4180	Reimburse for travel expense	08/31/2012	Kathleen Fondriest	827.76	Kathy Foundri	Director of Nursing	DON Training	Plymouth,MN	Airfare, lodging
4701	4140	Interim MDS Coordinator - K. K	08/21/2012	POLARIS GROUP	5,734.63	K.Kooy	Interim MDS Coordinator	----	----	airfare, gas, meals, lodging
4701	4140	Interim MDS Coordinator I - K.	08/21/2012	POLARIS GROUP	5,644.90	K.Kooy	Interim MDS Coordinator	----	----	airfare, gas, meals, lodging
4701	4144	Gas for vehicles	09/18/2012	Exxon Mobil Business Card	585.31	Marya Jordan	Transportation	----	----	gas for company vehicles
4701	4140	Interim MDS Coordinator - Augu	09/17/2012	POLARIS GROUP	5,829.55	K.Kooy	Interim MDS Coordinator	----	----	airfare, gas, meals, lodging
4701	4144	gas for vehicles	09/23/2012	Exxon Mobil Business Card	510.98	Drivers	Transportation	----	----	gas for company vehicles
4701	4144	Gas for company vehicles	10/24/2012	Exxon Mobil Business Card	530.82	Drivers	Transportation	----	----	gas for company vehicles
4701	4180	FIA credit cards	11/30/2012	FIA Card Services	1,133.05	Marya Jordan	Healthcatre Admin.	LeadingAge	Denver, CO	Airfare, lodging
4701	4140	FOLIO #493057 A - GROU CHX	11/15/2012	Hampton Inn & Suites	440.19	Corp. Employ	Various	Travel to campuses	Various	Lodging
4701	4144	vehicle gasoline	11/23/2012	Exxon Mobil Business Card	388.01	Drivers	Transportation	----	----	gas for company vehicles
4701	4144	Gas for company cars	12/24/2012	Exxon Mobil Business Card	422.63	Drivers	Transportation	----	----	gas for company vehicles
4701	4140	final interim MDS coordinator	12/01/2012	POLARIS GROUP	5,120.24	K.Kooy	Interim MDS Coordinator	----	----	airfare, gas, meals, lodging
4701	4144	Gas for company cars	01/24/2013	Exxon Mobil Business Card	400.63	Drivers	Transportation	----	----	gas for company vehicles

Total This Sheet: -

Total of Payroll-Reimbursed Travel: 383.62

Total Travel And Auto: 383.62

Adjustment -22.5

Total Travel & Audto 361.12

Covenant Health Care - Batavia
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Seminar Schedule
02/01/12-01/31/13

Account Description	Dept	Department	Entry Description	Name of Seminar	Employee	Date of Seminar	Seminar Location	Amount
Conferences And Seminars	4140	Nursing	02/29/2012 APIC Chicago	Infection Prevention in the Long-term	Kathy Foundriest	3/8/12 - 3/9/12	Hilton, Lisle, IL	75.00
Conferences And Seminars	4140	Nursing	03/31/2012 FIA Card Services	AANAC	Joyce Pancothine	4/18/12 - 4/20/12	Jacksonville, FL	110.00
Conferences And Seminars	4180	Admin & General	09/30/2012 FIA Card Services	Global Leadership Summit-DVD/Bo	Holmstad Campus-MHC	10/15/12	Holmstad Campus	#####
Conferences And Seminars	4150	Dining	10/31/2012 FIA Card Services	Webinar training registration for Foc	Alex Gilmore	11/8/12	Holmstad Campus	25.00
Conferences And Seminars	4180	Admin & General	11/30/2012 FIA Card Services	Leading Age Conference	Marya Jordan	8/20/12 - 8/24/12	Denver, CO	799.00
Conferences And Seminars	4140	Nursing	02/29/2012 Illinois Council on L	In Depth Training for Wound Care	Joanne Goebel	2/21/12 - 2/22/12	Hilton, Oak Lawn, IL/Holiday Inn, Skokie, IL	195.00
Conferences And Seminars	4140	Nursing	03/31/2012 Illinois Council on L	Reducing Hospital Re-Admission	Chris Brouch	3/21/12	Hilton, Oak Lawn, IL	165.00
Conferences And Seminars	4141	Activities	03/31/2012 Northern Illinois Act	Educational Conference for Activity	Tina Smith	May 2012		40.00
Conferences And Seminars	4180	Admin & General	03/31/2012 NORTHERN ILLINOIS UNI	LSN Conference	16-20 Employees	5/2/13 - 5/4/13	Navy Pier-Chicago,IL	#####
Conferences And Seminars	4141	Activities	05/31/2012 Oakton Community Coll	36hr orientation course	Karin Klockars	6/12/12 - 6/28/12	Oakton Community College	458.00
Conferences And Seminars	4140	Nursing	04/30/2012 Pathway Health Servic	Rehab Certificate Program	Joann Sandstrom	5/11/12	Westmont, IL	749.00
Conferences And Seminars	4142	Chaplains	04/30/2012 Sally Pierce	Central Conference Annual Meeting	Sally Pierce	4/26/12	Sheboygan, WI	75.00
Conferences And Seminars	4143	Social Services	05/31/2012 The Comprehensive Gro	Social Services Documation Works	Kim Bartells/Donna Swiney	6/4/12	La Grange Park, IL	178.00
Training								<u>1134.26</u>
								#####

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

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

Facility Name & ID Number Covenant HCC-Batavia

0025577

Report Period Beginning: 02/01/12

Ending: 01/31/13

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/Leading Age \$17238
- (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. \$ 45,919 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. \$ 224,896
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. \$ 2,710
- (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. \$
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Plante Moran
- (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.