FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0025577

Facility Name: Covenant Hlth Cr Ctr Batavia

Address: 831 N Batavia Avenue (Number) Batavia (City) 60510 (Zip Code)

County: Kane

Telephone Number: (630) 879-430 **Fax #** (630) 879-8483

HFS ID Number:

Date of Initial License for Current Owners: 05/09/1980

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Andrew Cutler **Telephone Number:** (847) 374-0400
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02/01/2015 to 01/31/2016 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler, Managing Director
(Firm Name & Address) FGMK, LLC, 2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015
(Telephone) (847) 374-0400 Fax # (847) 374-0420

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,582	13,470	6,955	29,007	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,582	13,470	6,955	29,007	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.27%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 05/06/1980

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	402,068	42,404	63,100	507,572		507,572		507,572			1
2	Food Purchase		246,597		246,597		246,597	(2,797)	243,800			2
3	Housekeeping	91,179	37,594	203	128,976		128,976		128,976			3
4	Laundry	46,144	6,361	37,664	90,169		90,169		90,169			4
5	Heat and Other Utilities			176,326	176,326		176,326		176,326			5
6	Maintenance	191,358	11,228	195,965	398,551		398,551	(1,896)	396,655			6
7	Other (specify):*											7
8	**TOTAL General Services**	730,749	344,184	473,258	1,548,191		1,548,191	(4,693)	1,543,498			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	3,215,953	59,730	44,938	3,320,621		3,320,621		3,320,621			10
10a	Therapy		670		670		670		670			10a
11	Activities	154,369	12,523	5,671	172,563		172,563		172,563			11
12	Social Services	210,712		12,047	222,759		222,759	(7,103)	215,656			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,581,034	72,923	74,656	3,728,613		3,728,613	(7,103)	3,721,510			16
	C. General Administration											
17	Administrative	136,411		495,588	631,999		631,999	(495,588)	136,411			17
18	Directors Fees											18
19	Professional Services			63,355	63,355		63,355		63,355			19
20	Dues, Fees, Subscriptions & Promotions			115,274	115,274		115,274	(66,919)	48,355			20
21	Clerical & General Office Expenses	316,231	28,293	443,079	787,603		787,603	188,783	976,386			21
22	Employee Benefits & Payroll Taxes			873,184	873,184		873,184		873,184			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,668	18,668		18,668	(2,950)	15,718			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			91,945	91,945		91,945		91,945			26
27	Other (specify):*											27
28	**TOTAL General Administration**	452,642	28,293	2,101,093	2,582,028		2,582,028	(376,674)	2,205,354			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,764,425	445,400	2,649,007	7,858,832		7,858,832	(388,470)	7,470,362			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 Hlth Cr Ctr Batavia #0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			635,712	635,712		635,712		635,712			30
31	Amortization of Pre-Op. & Org.			15,860	15,860		15,860		15,860			31
32	Interest			614,721	614,721		614,721	(249,086)	365,635			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			16,730	16,730		16,730		16,730			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,283,023	1,283,023		1,283,023	(249,086)	1,033,937			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		329,720	816,583	1,146,303		1,146,303		1,146,303			39
40	Barber and Beauty Shops		88	14,964	15,052		15,052		15,052			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			197,523	197,523		197,523		197,523			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		329,808	1,029,070	1,358,878		1,358,878		1,358,878			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,764,425	775,208	4,961,100	10,500,733		10,500,733	(637,556)	9,863,177			45

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,797)	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				9
10	Interest and Other Investment Income	(249,086)	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	(2,806)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,471)	21		24
25	Fund Raising, Advertising and Promotional	(66,919)	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	(138,500)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (479,579)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (479,579)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Covenant Hlth Cr Ctr Batavia

ID# 0025577

Report Period Beginning: 02/01/2015

Ending: 01/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Revenue	$ (7,103)	12	1
2	Transfer Temp Restr For Oper	(1,272)	21	2
3	Guest Apartment Revenue	(1,870)	06	3
4	Other Operating Income	(198)	21	4
5	Intercampus Revenue	(125,081)	21	5
6	Maintenance Service	(26)	06	6
7	Non-Allowable Travel	(1,452)	24	7
8	Non-Allowbale Conf./Seminar	(1,498)	24	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**	(138,500)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,797)	0	0	0	0	0	0	0	0	0	0	(2,797)	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	(1,896)	0	0	0	0	0	0	0	0	0	0	(1,896)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,693)	0	0	0	0	0	0	0	0	0	0	(4,693)	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	(7,103)	0	0	0	0	0	0	0	0	0	0	(7,103)	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**	(7,103)	0	0	0	0	0	0	0	0	0	0	(7,103)	16
	C. General Administration													
17	Administrative	0	(495,588)	0	0	0	0	0	0	0	0	0	(495,588)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(66,919)	0	0	0	0	0	0	0	0	0	0	(66,919)	20
21	Clerical & General Office Expenses	(148,828)	337,611	0	0	0	0	0	0	0	0	0	188,783	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,950)	0	0	0	0	0	0	0	0	0	0	(2,950)	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**	(218,697)	(157,977)	0	0	0	0	0	0	0	0	0	(376,674)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(230,493)	(157,977)	0	0	0	0	0	0	0	0	0	(388,470)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia **#** 0025577 **Report Period Beginning:** 02/01/2015 **Ending:** 01/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(249,086)	0	0	0	0	0	0	0	0	0	0	(249,086)	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**	(249,086)	0	0	0	0	0	0	0	0	0	0	(249,086)	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):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(479,579)	(157,977)	0	0	0	0	0	0	0	0	0	(637,556)	45

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Retirement Communities	100%	See Page 6-Supp				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Office Expense - CRC Alloc.	$			$ 688,453	$ 688,453	1
2	V	21	Other Operating Expense	4,000				(4,000)	2
3	V	21	Centralized Billing	91,898				(91,898)	3
4	V	21	IS Software/Capital Fees	212,520				(212,520)	4
5	V	21	Legal Services	10,000				(10,000)	5
6	V	17	Management Service Fees	495,588				(495,588)	6
7	V	21	Payroll Services	32,424				(32,424)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 846,430			$ 688,453	$ * (157,977)	14

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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	Jon P. Aagaard, M.D.	BOD	Covenant Village Care Center - Florida	Plantation, FL				1
2	Pamela Christensen	BOD	Brandel Care Center	Northbrook, IL				2
3	Kara Davis	BOD	Windsor Park Manor	Carol Stream, IL				3
4	Rev. Harvey Drake✞	BOD	Covenant Village Care Center - Turlock	Turlock, CA				4
5	Mark Eastburg	BOD	Mount Miguel Covenant Village	Spring Valley, CA				5
6	James Elving✞	BOD	Samarkand Skilled Nursing	Santa Barbara, CA				6
7	Marc Espinosa✞	BOD	Colonial Acres Care Center	Golden Valley, MN				7
8	Carol A. Findling	BOD	Covenant Vilage of the Great Lakes	Grand Rapids, MI				8
9	Lorene G. Flewellen✞	BOD	Covenant Village of Colorado	Westminster, CO				9
10	Rhoda Friesen✞	BOD	Pilgrim Manor	Cromwell, CT				10
11	Thomas F. Heywood	BOD	Covenant Shores	Mercer Island, WA				11
12	Donald Hodgkinson	BOD	Brandel Manor	Turlock, CA				12
13	Kathy Holmgren	BOD						13
14	Jody Holt	BOD						14
15	Scott Macdonald	BOD						15
16	Marlene E. Stante	BOD						16
17	Anne Vining	BOD						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 Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	See Page 6-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 Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 1/31/2016

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: 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 Alloc.	Total Expense			$	$		$ 688,453	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					$	$		$ 688,453	25

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	2011B ILL TX Bonds		X	Refinance Debt			$	$ 235,841			$ 12,219	1
2	2012A CO TX Bonds		X	Refinance Debt				10,236,505			507,871	2
3	2012C CO TX Bonds		X	Refinance Debt				1,698,011			94,631	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 12,170,357			$ 614,721	9
	B. Non-Facility Related*											
10	Interest Income										(249,086)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (249,086)	14
15	TOTALS (line 9+line14)						$	$ 12,170,357			$ 365,635	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.)**

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 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:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

N/A facility does not pay real estate taxes due to not-for-profit exempt status.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Hlth Cr Ctr Batavia COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0025577

CONTACT PERSON REGARDING THIS REPORT Andrew B. Cutler

TELEPHONE (847) 374-0400 FAX #: (847) 374-0420

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

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

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

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

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 [X] NO
If so, please complete the following:

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

3. Current Period Amortization: _____ 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1980	$ 85,758	1
2					2
3	TOTALS			$ 85,758	3

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1980	1980	$ 2,546,788	$		$	$	$ 2,358,719	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1982	4,706		20				9
10					(4,706)						10
11	Various			1983	16,662		20				11
12					(16,662)						12
13	Various			1984	832		20				13
14	Various			1986	14,644		20				14
15	Various			1987	12,021		20				15
16	Various			1988	9,128		20				16
17	Various			1989	15,226		20				17
18	Various			1990	40,083		20				18
19	Various			1991	18,354		20				19
20	Various			992	18,931		20				20
21	Various			1993	90,076		20				21
22	Various			1994	56,935		20				22
23	Various				(56,935)		20				23
24	Various			1995	84,370		20	2,109	2,109	84,370	24
25	Various				(84,370)						25
26	Various			1996	9,674		20	484	484	9,433	26
27	Various			1997	4,570		20	229	229	4,227	27
28	Various			1998	5,750		20	287	287	5,031	28
29	Various			1999	5,092		20	255	255	4,201	29
30	Various			2000	9,810		20	491	491	7,603	30
31	Various			2001	1,541		20	77	77	1,041	31
32	Various			2004	8,747,969		20	529,966	529,966	6,373,147	32
33	Various			2005	20,996		20	1,326	1,326	13,921	33
34	Various			2008	126,294		20	6,315	6,315	51,569	34
35	Various			2009	56,450		20	2,823	2,823	26,074	35
36	Book Depreciation					635,712					36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2010	$ 117,342	$	20	$ 5,867	$ 5,867	$ 41,069	37
38	Hobart Disposer	2011	3,555		20	178	178	730	38
39	2Nd Floor Mhc Shower	2011	5,886		20	294	294	1,205	39
40	Mhc - Walk- In Freezer	2011	79,330		20	3,967	3,967	19,835	40
41	Courtyard Door Latch	2012	2,921		20	146	146	584	41
42	MHC South Exit Door	2012	5,286		10	528	528	1,850	42
43	MHC 2nd Fl. Corridor Remodel- Flooring, Wall Finishes/Paint,								43
44	Electrical Fixtures	2012	51,681		20	5,178	5,178	18,024	44
45	Remodel 11 Mulberry Rooms-Floor, Plumbing, Structural/Walls,								45
46	Wall Finishes/Paint, Window Coverings, Electrical Fixtures	2012	175,204		20	17,520	17,520	61,321	46
47	Dining Room Blinds	2013	3,033		20	152	152	379	47
48	Stairwell Railing- LSC Compliance Tag K034	2013	9,314		20	466	466	1,164	48
49	Patient Room Detection Lighting	2013	5,045		20	252	252	630	49
50	MHC Cross Corridor Smoke Barrier Detector System-								50
51	LSC Compliance Tag K024- First Floor Cooridor Northwest								51
52	Section of Building	2014	19,569		20	978	978	1,468	52
53	MHC Lobby ADA Accessible Reception Desk and Private Meeting								53
54	Space (Steel Framing, drywall, electrical, ceiling tiles,								54
55	carpet light fixtures, paint, quartz countertop and Adjustments								55
56	to fire suppression sysetm.	2014	154,098		10	15,410	15,410	23,115	56
57	MHC Speech Therapy Office	2015	6,328		20	158	158	158	57
58	MHC Main Entry Call System	2015	5,499		20	137	137	137	58
59	MHC Employee Lounge, Floors, Walls, Lighting	2015	39,916		20	998	998	998	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,438,236	$ 635,712		$ 596,590	$ 596,590	$ 9,112,002	70

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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	$ 991,363	$	$ 37,793	$ 37,793		$ 531,051	71
72	Current Year Purchases	26,582		1,329	1,329		1,329	72
73	Fully Depreciated Assets							73
74	Disposals	(270,997)						74
75	TOTALS	$ 746,948	$	$ 39,122	$ 39,122		$ 532,380	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,270,942	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 635,712	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 635,712	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,644,382	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	Construction In Progress	$ 314,146	92
93			93
94			94
95		$ 314,146	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 Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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: *

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: $ 13,633 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

* 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.

Description	Amount
Postage Meter	648
Copier	11,187
Tents/Chairs	1,798
	13,633

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	$ 275,574		$	$		$ 275,574	1
2	Licensed Speech and Language Development Therapist	39-03	hrs	92,323					92,323	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs	373,500					373,500	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				221,633		221,633	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			75,186			111,184		186,370	13
14	TOTAL			$ 816,583		$	$ 332,817		$ 1,149,400	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.

Covenant Health Care Center - Batavia
0025577
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Special Services - Supplies (Column 6 - Other)	**Amount**
Nursing & Med Supp	106,920
Equipment Rental/Repairs	2,520
O2 Nebulizers & Concentrators	577
VAC Freedom Rentals	1,167
	111,184

Special Services - Outside (Column 5 - Other)	**Amount**
Laboratory and X-Ray (Lax) Exp	56,539
Oxygen (Oxy) Expense	18,647
	75,186

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia **#** 0025577 **Report Period Beginning:** 02/01/2015 **Ending:** 01/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 01/31/2016 **(last day of reporting year)**

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 150	$	1
2	Cash-Patient Deposits	26,402		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (36,553))	1,016,514		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	5,613		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	151,725		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,200,404	$	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	11,898,147		14
15	Leasehold Improvements, at Historical Cost	14,190		15
16	Equipment, at Historical Cost	746,949		16
17	Accumulated Depreciation (book methods)	(9,644,382)		17
18	Deferred Charges	154,582		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): See Attached	7,607,234		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,862,478	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,062,882	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 60,560	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	221,928		29
30	Accrued Salaries Payable	330,639		30
31	Accrued Taxes Payable (excluding real estate taxes)	57,710		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	98,869		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	415,018		36
37	See Attached	351,392		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,536,116	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	11,948,429		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 11,948,429	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,484,545	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,421,663)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,062,882	$	48

***(See instructions.)**

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Other Current Assets:	Amount
Other-ACC INT DEBT SERVICE RESERVES	10,954.00
Other-BOND SINKING FUND	42,325.00
Other-BOND INTEREST FUND	98,446.00
	151,725

Other Non-Current Assets:	Amount
Benevolent Care Fund	237,806
Property Replacement Fund	13
Capital Reserve Fund	95,620
Debt Service Reserve Fund	1,263,935
Asset Clearing	314,146
Original Issue Discount (OID), Net	19,668
Admin - Zone 91	5,676,046
	7,607,234

Other Current Liabilities:	Amount
Other-RESIDENT TRUST FUNDS	(26,402.00)
Other-OTHER CURRENT LIABILITIES	(386,916.00)
Other-Accrued Other Expense	(1,700.00)
	(415,018)

Other Current Liabilities	Amount
Other-ORIGINAL ISSUE PREMIUM (OIP)	(525,091.00)
Other-ACCUMULATED ACCRETION - OIP	173,699.00
	(351,392)

Other Non-Current Liabilities:	Amount

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,124,585)	1
2	Restatements (describe):		2
3	**Irrevocable Trust Restatement**	950	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,123,635)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(298,028)	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)**	$ (298,028)	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)**	$ (1,421,663)	24 *

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

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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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,691,935	1
2	Discounts and Allowances for all Levels	(2,994,930)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,697,005	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,509,310	6
7	Oxygen	14,030	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,523,340	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	18,515	13
14	Non-Patient Meals	2,797	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,870	16
17	Sale of Drugs	231,454	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	55,451	19
20	Radiology and X-Ray		20
21	Other Medical Services	225,595	21
22	Laundry	64,062	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 599,744	23
	D. Non-Operating Revenue		
24	Contributions	2,806	24
25	Interest and Other Investment Income***	249,086	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 251,892	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	130,724	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 130,724	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,202,705	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,548,191	31
32	Health Care	3,728,613	32
33	General Administration	2,582,028	33
	B. Capital Expense		
34	Ownership	1,283,023	34
	C. Ancillary Expense		
35	Special Cost Centers	1,161,355	35
36	Provider Participation Fee	197,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,500,733	40
41	**Income before Income Taxes (line 30 minus line 40)****	(298,028)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (298,028)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,266,017	44
45	Private Pay - Net Inpatient Revenue	4,616,771	45
46	Medicare - Net Inpatient Revenue	1,476,179	46
47	Other-(specify) MCO	338,038	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,697,005	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	
Other-TRANSPORTATION REVENUE	(7,103.00)	Adj on 5a
Other-MAINTENANCE SERVICES	(26.00)	Adj on 5a
Other-TRANSFER TEMP RESTR FOR OPER	(1,272.00)	Adj on 5a
Other-OTHER OPERATING INCOME	(198.00)	Adj on 5a
Other-INVESTMENT PROPERTY REVENUE	(1,584.00)	
Other-INTERCAMPUS REVENUE	(125,081.00)	Adj on 5a
Other-GAIN (LOSS)-DISP OF FIXED ASSETS	4,540.00	
	(130,724.00)	

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,968	2,080	$ 107,685	$ 51.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	40,726	44,199	1,562,749	35.36	3
4	Licensed Practical Nurses	5,822	6,232	180,307	28.93	4
5	CNAs & Orderlies	77,636	85,187	1,334,739	15.67	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,947	2,142	36,180	16.89	9
10	Activity Assistants	7,734	8,478	118,189	13.94	10
11	Social Service Workers	6,938	7,577	210,712	27.81	11
12	Dietician					12
13	Food Service Supervisor	2,679	2,912	63,597	21.84	13
14	Head Cook	8,208	8,752	137,729	15.74	14
15	Cook Helpers/Assistants	16,714	17,509	200,742	11.47	15
16	Dishwashers					16
17	Maintenance Workers	9,887	10,943	191,358	17.49	17
18	Housekeepers	7,176	8,092	91,179	11.27	18
19	Laundry	3,528	3,819	46,144	12.08	19
20	Administrator	2,141	2,325	136,411	58.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,585	13,480	316,231	23.46	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	1,616	1,726	30,473	17.66	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	207,305	225,453	$ 4,764,425 *	$ 21.13	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	12,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	41	2,653	10-3	38
39	Pharmacist Consultant	Monthly	5,921	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	2,754	11-3	44
45	Social Service Consultant	122	8,036	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	214	$ 31,364		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	484	$ 21,760	10-3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	477	9,545	10-3	52
53	TOTAL (lines 50 - 52)	961	$ 31,305		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Maya Jordan	Administrator	0	$ 136,411
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 136,411

B. Administrative - Other

Description	Amount
Covenant Retirement Communities - Management Fees	$ 495,588
TOTAL (agree to Schedule V, line 17, col. 3)	$ 495,588
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Disney	Customer Svc Standards	$ 14,854
Holleran	Resident Survey	8,084
Jeremy Brune & Assoc.	Accounting	2,200
FGMK, LLC	Consulting	4,250
Relias Learning	Online Continuing Education	4,674
Polaris	Medicare Operation Asses	9,500
Mix Solutions	Data Processsing	6,100
Marcum	Accounting/Consulting	4,630
Plante & Moran	Audit	4,038
Polsinelli	Legal	5,024
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 63,354

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 76,891
Unemployment Compensation Insurance	2,090
FICA Taxes	348,145
Employee Health Insurance	312,885
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403B Matching	37,195
Group Life Insurance	9,412
Pension Plan	66,204
Phyiscals, Tuition, Other	18,863
Uniforms	1,499
TOTAL (agree to Schedule V, line 22, col.8)	$ 873,184

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	20,085
Health Care Worker Background Check	
(Indicate # of checks performed 369)	8,894
Patient Background Checks 401	5,820
Dues & Subscriptions	9,291
Public Relations	15,427
Advertising	51,492
Licenses & Permits	2,275
Less: Public Relations Expense	(15,427)
Non-allowable advertising	(51,492)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 48,355

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,020
Seminar Expense	7,698
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,718

* Attach copy of IMRF notifications

**See instructions.

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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-$6,558**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **52,486** 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. $ **197,523**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **yes** Indicate the amount. $ **2,797**

(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) Has a schedule for the legal fees reported on the cost report been provided by the facility? **yes**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees