FOR BHF USE

LL1

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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0025577

Facility Name: Covenant Hlth Cr Ctr Batavia

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

County: Kane

Telephone Number: (630)879-4300 **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
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

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 02/01/13 to 01/31/14 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: 02/01/13 Ending: 01/31/14

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	8,889	16,556	5,709	31,154	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,889	16,556	5,709	31,154	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.22%

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 5,138

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] 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 Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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	367,595	43,841	60,092	471,528		471,528	(15,474)	456,054			1
2	Food Purchase		248,366		248,366		248,366	(6,873)	241,493			2
3	Housekeeping	104,126	35,520		139,646		139,646		139,646			3
4	Laundry	57,802	4,908	33,925	96,635		96,635		96,635			4
5	Heat and Other Utilities			167,637	167,637		167,637		167,637			5
6	Maintenance	234,359	9,878	191,268	435,505		435,505	(1,023)	434,482			6
7	Other (specify):*											7
8	**TOTAL General Services**	763,882	342,513	452,922	1,559,317		1,559,317	(23,370)	1,535,947			8
	B. Health Care and Programs											
9	Medical Director			13,000	13,000		13,000		13,000			9
10	Nursing and Medical Records	2,803,314	47,592	74,915	2,925,821		2,925,821		2,925,821			10
10a	Therapy											10a
11	Activities	120,474	14,799	5,167	140,440		140,440		140,440			11
12	Social Services	185,933	115	1,800	187,848		187,848	(6,539)	181,309			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,109,721	62,506	94,882	3,267,109		3,267,109	(6,539)	3,260,570			16
	C. General Administration											
17	Administrative	112,523		455,772	568,295		568,295	(455,772)	112,523			17
18	Directors Fees											18
19	Professional Services			45,917	45,917		45,917	(123,585)	(77,668)			19
20	Dues, Fees, Subscriptions & Promotions			41,403	41,403		41,403	(28,141)	13,262			20
21	Clerical & General Office Expenses	230,947	26,348	448,497	705,792		705,792	434,167	1,139,959			21
22	Employee Benefits & Payroll Taxes			1,172,378	1,172,378		1,172,378	(5,298)	1,167,080			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,915	21,915		21,915	(2,787)	19,128			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			132,352	132,352		132,352		132,352			26
27	Other (specify):*											27
28	**TOTAL General Administration**	343,470	26,348	2,318,234	2,688,052		2,688,052	(181,416)	2,506,636			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,217,073	431,367	2,866,038	7,514,478		7,514,478	(211,325)	7,303,153			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: 02/01/13 Ending: 01/31/14

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			713,989	713,989		713,989	(133,618)	580,371			30
31	Amortization of Pre-Op. & Org.			21,601	21,601		21,601		21,601			31
32	Interest			633,168	633,168		633,168	(243,735)	389,433			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,849	10,849		10,849		10,849			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,379,607	1,379,607		1,379,607	(377,353)	1,002,254			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		239,980	711,627	951,607		951,607		951,607			39
40	Barber and Beauty Shops		148	25,487	25,635		25,635		25,635			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			212,114	212,114		212,114		212,114			42
43	Other (specify):*	14,253			14,253		14,253	(14,253)				43
44	**TOTAL Special Cost Centers**	14,253	240,128	949,228	1,203,609		1,203,609	(14,253)	1,189,356			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,231,326	671,495	5,194,873	10,097,694		10,097,694	(602,931)	9,494,763			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: 02/01/13 Ending: 01/31/14

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	(6,873)	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	(133,618)	30		9
10	Interest and Other Investment Income	(243,735)	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	(130,218)	21		24
25	Fund Raising, Advertising and Promotional	(28,141)	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	(93,163)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (635,748)		$	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)	32,817		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 32,817		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (602,931)		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: 02/01/13

Ending: 01/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Revenue	$ (6,539)	12	1
2	Transfer Temp Restr For Oper	(258)	21	2
3	Guest Apartment Revenue	(945)	06	3
4	Other Operating Income	(3,974)	21	4
5	Intercampus Revenue	(37,886)	21	5
6	Procurement Rebates	(15,474)	01	6
7	Fundraising - Employee Benefits	(5,298)	22	7
8	Fundraising - Salary	(14,253)	43	8
9	Legal Services - Adj	(5,671)	19	9
10	Non-Allowable Seminar	(2,787)	24	10
11	Maintenance Service	(78)	06	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**	(93,163)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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	(15,474)	0	0	0	0	0	0	0	0	0	0	(15,474)	1
2	Food Purchase	(6,873)	0	0	0	0	0	0	0	0	0	0	(6,873)	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	(1,023)	0	0	0	0	0	0	0	0	0	0	(1,023)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(23,370)	0	0	0	0	0	0	0	0	0	0	(23,370)	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	(6,539)	0	0	0	0	0	0	0	0	0	0	(6,539)	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**	(6,539)	0	0	0	0	0	0	0	0	0	0	(6,539)	16
	C. General Administration													
17	Administrative	0	(455,772)	0	0	0	0	0	0	0	0	0	(455,772)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,671)	(117,914)	0	0	0	0	0	0	0	0	0	(123,585)	19
20	Fees, Subscriptions & Promotions	(28,141)	0	0	0	0	0	0	0	0	0	0	(28,141)	20
21	Clerical & General Office Expenses	(172,336)	606,503	0	0	0	0	0	0	0	0	0	434,167	21
22	Employee Benefits & Payroll Taxes	(5,298)	0	0	0	0	0	0	0	0	0	0	(5,298)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,787)	0	0	0	0	0	0	0	0	0	0	(2,787)	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**	(214,233)	32,817	0	0	0	0	0	0	0	0	0	(181,416)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(244,142)	32,817	0	0	0	0	0	0	0	0	0	(211,325)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia **#** 0025577 **Report Period Beginning:** 02/01/13 **Ending:** 01/31/14

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	(133,618)	0	0	0	0	0	0	0	0	0	0	(133,618)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(243,735)	0	0	0	0	0	0	0	0	0	0	(243,735)	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**	(377,353)	0	0	0	0	0	0	0	0	0	0	(377,353)	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):*	(14,253)	0	0	0	0	0	0	0	0	0	0	(14,253)	43
44	**TOTAL Special Cost Centers**	(14,253)	0	0	0	0	0	0	0	0	0	0	(14,253)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(635,748)	32,817	0	0	0	0	0	0	0	0	0	(602,931)	45

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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.	$	Covenant Retirement Communities		$ 738,743	$ 738,743	1
2	V	21	Other Operating Expense	49,356	Covenant Retirement Communities			(49,356)	2
3	V	19	Consultant Services	83,416	Covenant Retirement Communities			(83,416)	3
4	V	21	In Service Fees- Software	82,884	Covenant Retirement Communities			(82,884)	4
5	V	19	Legal Services	5,208	Covenant Retirement Communities			(5,208)	5
6	V	17	Management Service Fees	455,772	Covenant Retirement Communities			(455,772)	6
7	V	19	Payroll Services	29,290	Covenant Retirement Communities			(29,290)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 705,926			$ 738,743	$ * 32,817	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: 02/01/13 Ending: 01/31/14

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						12
13	Kathy Holmgren	BOD						13
14	Judy Holt	BOD						14
15	Marlene E. Stante	BOD						15
16	Anne Vining	BOD						16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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 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 Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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 Allocation	Total Expense			$	$		$ 738,743	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					$	$		$ 738,743	25

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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			$	$ 265,224			$ 13,183	1
2	2012A CO TX Bonds		X	Refinance Debt				10,133,505			509,945	2
3	2012C CO TX Bonds		X	Refinance Debt				2,644,002			110,040	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 13,042,731			$ 633,168	9
	B. Non-Facility Related*											
10	Interest Income										(243,735)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (243,735)	14
15	TOTALS (line 9+line14)						$	$ 13,042,731			$ 389,433	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: 02/01/13 Ending: 01/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 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 2014 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:			
	2009		8
	2010		9
	2011		10
	2012		11
	2013		12

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

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.**

2013 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 2013 on the lines provided below. Enter only the portion of th cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir 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 2013.

	(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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 02/01/13 Ending: 01/31/14

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: 02/01/13 Ending: 01/31/14

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	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1982	4,706		20			4,706	9
10	Various			1983	16,662		20			16,662	10
11	Various			1984	832		20			832	11
12	Various			1986	14,644		20			14,644	12
13	Various			1987	12,021		20			12,021	13
14	Various			1988	9,128		20			9,128	14
15	Various			1989	15,226		20			15,226	15
16	Various			1990	40,083		20			40,083	16
17	Various			1991	18,354		20			18,354	17
18	Various			1992	18,931		20			19,831	18
19	Various			1993	90,076		20			90,076	19
20	Various			1994	56,935		20	2,847	2,847	59,782	20
21	Various			1995	84,370		20	4,219	4,219	84,371	21
22	Various			1996	9,674		20	484	484	9,191	22
23	Various			1997	4,570		20	229	229	4,114	23
24	Various			1998	5,750		20	288	288	4,889	24
25	Various			1999	5,092		20	255	255	4,074	25
26	Various			2000	9,810		20	491	491	7,359	26
27	Various			2001	1,541		20	77	77	1,002	27
28	Various			2004	8,747,969		20	437,398	437,398	4,811,382	28
29	Various			2005	20,996		20	1,050	1,050	10,498	29
30	Various			2008	126,294		20	6,315	6,315	44,204	30
31	Various			2009	56,450		20	2,823	2,823	16,936	31
32											32
33											33
34											34
35											35
36											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.

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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	Lighting Improvement	2010	$ 18,500	$	20	$ 925	$ 925	$ 4,625	37
38	Lighting Improvement	2010	22,280		20	1,114	1,114	5,570	38
39	Automatic Trash Doors	2010	5,077		20	254	254	1,270	39
40	Therapy Heater	2010	4,273		20	214	214	1,070	40
41	Safety Barrier	2010	15,000		20	750	750	3,750	41
42	Vertical Shaft	2010	28,360		20	1,418	1,418	7,090	42
43	237 Cabinets	2010	3,356		20	168	168	840	43
44	Mhc Chiller Repair	2010	3,642		20	182	182	910	44
45	Mhc Compressor Repair	2010	4,483		20	224	224	1,120	45
46	Mhc Chiller Repair	2010	2,919		20	146	146	730	46
47	Mhc Soil Application	2010	6,584		20	329	329	1,645	47
48	Ccs Painting	2010	2,868		20	143	143	715	48
49	Hobart Disposer	2011	3,555		20	178	178	374	49
50	2Nd Floor Mhc Shower	2011	5,886		20	294	294	617	50
51	Mhc - Walk- In Freezer	2011	79,330		20	3,967	3,967	11,901	51
52	Courtyard Door Latch	2012	2,921		20	146	146	292	52
53	MHC South Exit Door	2012	5,286		20	264	264	528	53
54	MHC 2nd Fl. Corridor Remodel- Flooring, Wall Finishes/Paint,								54
55	Electrical Fixtures	2012	49,081		20	2,454	2,454	4,908	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	9,902	57
58	Dining Room Blinds	2013	3,033		20	152	152	152	58
59	Stairwell Railing- LSC Compliance Tag K034	2013	9,081		20	454	454	454	59
60	Patient Room Detection Lighting	2013	5,045		20	252	252	252	60
61									61
62									62
63									63
64									64
65									65
66	Related Building Company (Pages 12F & 12G)								66
67	Related Party Allocations (Pages 12H & 12I)								67
68	Financial Statement Depreciation			713,989			(713,989)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,296,494	$ 713,989		$ 475,455	$ (238,534)	$ 5,358,080	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: 02/01/13 Ending: 01/31/14

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	$ 1,049,156	$	$ 104,916	$ 104,916	10	$ 773,472	71
72	Current Year Purchases	6,726				10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,055,882	$	$ 104,916	$ 104,916		$ 773,472	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)	$ 13,438,134	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 713,989	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 580,371	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (133,618)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,131,552	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 Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 10,849 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
Copier	10016.15
Postage Machine	833
	10849.15

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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.

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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	$		$ 264,956	$		$ 264,956	1
2	Licensed Speech and Language Development Therapist		hrs			87,744			87,744	2
3	Licensed Recreational Therapist	39-03	hrs							3
4	Licensed Physical Therapist		hrs			309,493			309,493	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-02	# of prescrpts				138,348		138,348	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):					49,343	99,296		148,639	13
14	TOTAL			$		$ 711,536	$ 237,644		$ 949,180	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.

Special Services - Supplies (Column 6 - Other)	**Amount**
Nursing & Med Supp	86,702
Equipment Rental/Repairs	12,594
	99,296

Special Services - Outside (Column 5 - Other)	**Amount**
Laboratory and X-Ray (Lax) Exp	36,365
Oxygen (Oxy) Expense	13,069
	49,434

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/14 (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	3,803		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	762,614		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,758		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	152,122		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 929,447	$	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	11,837,676		14
15	Leasehold Improvements, at Historical Cost	14,190		15
16	Equipment, at Historical Cost	868,249		16
17	Accumulated Depreciation (book methods)	(8,647,548)		17
18	Deferred Charges	185,606		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 Supplemental Schedule	7,620,226		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,964,157	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,893,604	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,884	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	249,401		29
30	Accrued Salaries Payable	288,602		30
31	Accrued Taxes Payable (excluding real estate taxes)	51,567		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	102,470		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	75,056		36
37	Original Issue Premium (net)	449,987		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,304,967	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	12,535,887		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)**	$ 12,535,887	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,840,854	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (947,250)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,893,604	$	48

*(See instructions.)

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Other Current Assets:	Amount
Acc Int Debt Service Reserves	10,171
	10,171

Other Non-Current Assets:	Amount
Benevolent Care Fund	237,806
Property Replacement Fund	3,671
Capital Reserve Fund	85,104
Debt Service Reserve Fund	1,280,138
Asset Clearing	18,898
Original Issue Discount (OID), Net	22,067
Admin - Zone 91	5,972,542
	7,620,226

Other Current Liabilities:	Amount
Resident Trust Funds	3,803
Other Current Liabilities	69,056
Design Contributions-General	1,320
Design Contributions-Project 1	877
	75,056

Other Non-Current Liabilities:	Amount

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (790,405)	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)**	$ (790,403)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(156,845)	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)**	$ (156,845)	17
	B. Transfers (Itemize):		
18	**Rounding**	(2)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (947,250)	24 *

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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	$ 9,549,714	1
2	Discounts and Allowances for all Levels	(1,696,751)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,852,963	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,276,179	6
7	Oxygen	27,354	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,303,533	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	34,126	13
14	Non-Patient Meals	6,873	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	945	16
17	Sale of Drugs	140,583	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	36,712	19
20	Radiology and X-Ray		20
21	Other Medical Services	174,076	21
22	Laundry	70,742	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 464,057	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	271,561	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 271,561	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	48,735	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 48,735	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,940,849	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,559,317	31
32	Health Care	3,267,109	32
33	General Administration	2,688,052	33
	B. Capital Expense		
34	Ownership	1,379,607	34
	C. Ancillary Expense		
35	Special Cost Centers	991,495	35
36	Provider Participation Fee	212,114	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,097,694	40
41	**Income before Income Taxes (line 30 minus line 40)****	(156,845)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (156,845)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 906,136	44
45	Private Pay - Net Inpatient Revenue	5,373,028	45
46	Medicare - Net Inpatient Revenue	1,424,150	46
47	Other-(specify) **Managed Care**	149,649	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,852,963	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	37,886	Pg. 5A
Telephone Revenue	12	Pg. 5A
Transportation Revenue	6,539	Pg. 5A
Transfer Temp Restr For Oper	258	
Other Operating Income	3,974	Pg. 5A
	48,669	

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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	1,544	1,872	$ 73,430	$ 39.23	1
2	Assistant Director of Nursing					2
3	Registered Nurses	38,589	41,588	1,335,057	32.10	3
4	Licensed Practical Nurses	4,746	5,580	151,881	27.22	4
5	CNAs & Orderlies	73,293	80,907	1,210,290	14.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,970	2,096	37,318	17.80	9
10	Activity Assistants	5,587	5,873	93,875	15.98	10
11	Social Service Workers	6,416	7,124	175,214	24.59	11
12	Dietician					12
13	Food Service Supervisor	2,544	2,860	55,775	19.50	13
14	Head Cook	7,582	8,129	123,547	15.20	14
15	Cook Helpers/Assistants	16,237	17,196	188,273	10.95	15
16	Dishwashers					16
17	Maintenance Workers	11,856	13,103	234,359	17.89	17
18	Housekeepers	8,672	9,550	104,126	10.90	18
19	Laundry	3,857	4,405	57,802	13.12	19
20	Administrator	1,901	2,265	112,523	49.68	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,346	10,527	230,947	21.94	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	1,303	1,583	32,656	20.63	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	676	750	14,253	19.00	33
34	TOTAL (lines 1 - 33)	196,119	215,408	$ 4,231,326 *	$ 19.64	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	Monthly	$ 60,092	01-03	35
36	Medical Director	Monthly	13,000	09-03	36
37	Medical Records Consultant	19	957	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	8,157	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		5,167	11-03	44
45	Social Service Consultant		1,800	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	19	$ 89,173		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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	676	750	14,124	18.83
Marketing			129	
	676	750	14,253	18.83

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marya Jordan	Administrator	0	$ 112,523
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 112,523

B. Administrative - Other

Description	Amount
Covenant Retirement Communities - Management Fees	$ 455,772
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 455,772

C. Professional Services

Vendor/Payee	Type	Amount
Polsinelli	Legal	$ 5,280
CSC	Legal	181
CRC	Legal	5,208
Plant Moran	Audit	6,569
FRR	Mock Survey	10,400
Sun Solutions	Mock Survey	7,270
Jeremy Brune & Associates	Accounting	2,200
FGMK	Accounting	4,650
Holleran Consulting	Staff Satisfaction Survey	4,158
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 45,916

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 135,998
Unemployment Compensation Insurance	19,115
FICA Taxes	303,180
Employee Health Insurance	545,889
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life/Disability	25,036
Pension Plan	88,682
Other Employee Benefits	21,169
Employee Recognition	6,460
Uniforms	780
403B Matching	26,069
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,172,378

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	$
Advertising: Employee Recruitment	860
Health Care Worker Background Check	
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	9,681
Licenses and Permits	2,721
Promotions/ PR	28,141
Less: Public Relations Expense	(28,141)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,262

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,180
Seminar Expense	5,735
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,915

* Attach copy of IMRF notifications

**See instructions.

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Seminar Schedule
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AcctDesc.	Unit	Acct	Date/Description	DR	CR
TRAINING CLASSES	4140	Nursing	11 12/05/13 AP I 1910032 21984A-TEC AMBUL	180	
CONFERENCES AND SEMINARS	4140	Nursing	07 08/31/13 GL N 39 reclass payroll reim	399	
TRAINING	4140	Nursing	05 06/20/13 AP I 1910187 21984A-TEC AMBUL	90	
TRAINING	4140	Nursing	05 06/20/13 AP I 1910187 21984A-TEC AMBUL	90	
CONFERENCES AND SEMINARS	4141	Activities	01 02/28/13 GL I 1910060 Klockars, K; ACT SH;	60	
CONFERENCES AND SEMINARS	4141	Activities	04 05/31/13 GL N 39 Klockars, K; TERRA ;	79	
CONFERENCES AND SEMINARS	4141	Activities	07 08/31/13 GL N 40 Klockars, K; PAYPAL;	220	
CONFERENCES AND SEMINARS	4141	Activities	09 10/31/13 GL N 19 Klockars, K; NCCDP;	100	
CONFERENCES AND SEMINARS	4141	Activities			
TRAINING	4150	Dining Services	05 06/30/13 GL N 41 accrue Sodexo - heal	5.8	
TRAINING	4150	Dining Services	06 07/01/13 AP I 1910113 22484SODEXO, INC	5.8	
TRAINING	4150	Dining Services	06 07/01/13 GL A 41 accrue Sodexo - heal		-5.8
TRAINING	4150	Dining Services	06 07/31/13 AP I 1910395 22484SODEXO, INC	12.76	
TRAINING	4150	Dining Services	07 08/31/13 AP I 1910296 22484SODEXO, INC	5.8	
TRAINING	4150	Dining Services	10 11/07/13 AP I 1910064 53290Innerspace	440	
CONFERENCES AND SEMINARS	4180	Administrative and General	01 02/28/13 GL I 1910060 Jordan, M; LIFE S; M	169	
CONFERENCES AND SEMINARS	4180	Administrative and General	02 03/12/13 AP I 1910012 21597NORTHERN IL	1481.04	
CONFERENCES AND SEMINARS	4180	Administrative and General	02 03/31/13 GL I 1910054 Dunker, J; LIFE S; S	59	
CONFERENCES AND SEMINARS	4180	Administrative and General	05 06/30/13 GL N 33 Jordan, M; EB IL; M	72	
CONFERENCES AND SEMINARS	4180	Administrative and General	07 08/31/13 GL N 40 Whitson, A; HEALTH;	189	
CONFERENCES AND SEMINARS	4180	Administrative and General	12 01/31/14 GL N 40 Jordan, M; LIFE S;	120	
TRAINING	4180	Administrative and General	03 04/30/13 AP I 1910042 38764FIA Card Se	40.75	
TRAINING	4180	Administrative and General	03 04/30/13 GL I 1910070 Jordan, M; PATHWA;	899	
TRAINING	4180	Administrative and General	04 05/01/13 AP I 1910087 53290Innerspace	80	
TRAINING	4180	Administrative and General	05 06/18/13 AP I 1910127 22916Alpha Graph	109.14	
TRAINING	4180	Administrative and General	05 06/30/13 AP I 1910135 42550BANK OF AME	67	
TRAINING	4180	Administrative and General	09 10/31/13 AP I 1910113 42550BANK OF AME	67	
TRAINING	4180	Administrative and General	11 12/31/13 GL N 19 Palm, L; HEALTH;	699.96	

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Travel Schedule
02/01/13-01/31/14

AcctDesc.	Unit	Acct	Date/Description	DR	CR
TRAVEL AND AUTO	Nursing	041-15-040	01 02/23/13 AP I 1910215 42166Pathway Hea	374.09	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/02/13 AP I 1910138 42166Pathway Hea	943.33	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/02/13 AP I 1910138 42166Pathway Hea	334.27	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/09/13 AP I 1910145 42166Pathway Hea	685.87	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/09/13 AP I 1910145 42166Pathway Hea	335.2	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/15/13 AP I 1910213 42166Pathway Hea	600	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/16/13 AP I 1910214 42166Pathway Hea	808.47	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/16/13 AP I 1910214 42166Pathway Hea	491.99	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/26/13 AP I 1910224 42166Pathway Hea	150	
TRAVEL AND AUTO	Nursing	041-15-040	02 03/28/13 AP I 1910163 42166Pathway Hea		-123.17
TRAVEL AND AUTO	Nursing	041-15-040	03 04/01/13 AP I 1910077 42166Pathway Hea	536.3	
TRAVEL AND AUTO	Nursing	041-15-040	03 04/01/13 AP I 1910077 42166Pathway Hea	506.61	
TRAVEL AND AUTO	Nursing	041-15-040	05 06/30/13 GL I 1910037 PR Dist PPE 06/13/13	68.4	
TRAVEL AND AUTO	Nursing	041-15-040	06 07/31/13 GL N 44 K.Fondriest payroll		-68.4
TRAVEL AND AUTO	Nursing	041-15-040	07 08/31/13 GL N 39 reclass payroll reim		-568.8
TRAVEL AND AUTO	Nursing	041-15-040	07 08/31/13 GL I 1910061 PR Dist PPE 08/15/13	568.8	
TRAVEL AND AUTO	Nursing	041-15-040	11 12/07/13 AP I 1910034 42166Pathway Hea	426.95	
TRAVEL AND AUTO	Nursing	041-15-040	11 12/14/13 AP I 1910133 42166Pathway Hea	431.63	
TRAVEL AND AUTO	Nursing	041-15-040	12 01/04/14 AP I 1910164 53717PATHWAY HEA	363.81	
TRAVEL AND AUTO	Nursing	041-15-040	12 01/11/14 AP I 1910171 53717PATHWAY HEA	385.68	
TRAVEL AND AUTO	Nursing	041-15-040	12 01/18/14 AP I 1910177 53717PATHWAY HEA	102.01	
TRAVEL AND AUTO	Nursing	041-15-040	12 01/18/14 AP I 1910177 53717PATHWAY HEA	65.52	
TRAVEL AND AUTO	Nursing	041-15-040	12 01/31/14 AP I 1910085 42166Pathway Hea	719.81	
TRAVEL AND AUTO	Nursing	041-15-040	12 01/31/14 AP I 1910085 42166Pathway Hea	473.94	
TRAVEL AND AUTO	Activities	041-20-041	05 06/30/13 GL N 33 Klockars, K; CHICAG;	13	
TRAVEL AND AUTO	Activities	041-20-041	05 06/30/13 GL N 33 Klockars, K; SQ TA;	12	

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/13 Ending: 01/31/14

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 $6,156**

(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. $ **46,475** 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. $ **212,114**
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. $ **6,873**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. No
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 out of Schedule V? **Yes**

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