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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

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)879-4300 **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
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: 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 02/01/14 to 01/31/2015 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: 02/01/14 Ending: 01/31/2015

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	10,804	15,728	4,597	31,129	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,804	15,728	4,597	31,129	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.15%

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 3,993

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:** 02/01/14 **Ending:** 01/31/2015

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

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY 9	10	
	A. General Services											
1	Dietary	361,317	41,605	62,214	465,136		465,136	(13,562)	451,574			1
2	Food Purchase		257,672		257,672		257,672	(2,831)	254,841			2
3	Housekeeping	102,148	40,430		142,578		142,578		142,578			3
4	Laundry	57,273	7,472	37,375	102,120		102,120		102,120			4
5	Heat and Other Utilities			177,805	177,805		177,805		177,805			5
6	Maintenance	244,890	22,057	270,859	537,806		537,806	(1,928)	535,878			6
7	Other (specify):*											7
8	**TOTAL General Services**	765,628	369,236	548,253	1,683,117		1,683,117	(18,321)	1,664,796			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	3,089,982	58,475	203,006	3,351,463		3,351,463		3,351,463			10
10a	Therapy		3,355	2,504	5,859		5,859		5,859			10a
11	Activities	127,744	13,912	7,917	149,573		149,573		149,573			11
12	Social Services	236,759		5,962	242,721		242,721	(5,327)	237,394			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,454,485	75,742	230,389	3,760,616		3,760,616	(5,327)	3,755,289			16
	C. General Administration											
17	Administrative	108,542		471,540	580,082		580,082	(471,540)	108,542			17
18	Directors Fees											18
19	Professional Services			64,752	64,752		64,752	(3,200)	61,552			19
20	Dues, Fees, Subscriptions & Promotions			67,085	67,085		67,085	(27,078)	40,007			20
21	Clerical & General Office Expenses	215,406	30,931	238,856	485,193		485,193	354,353	839,546			21
22	Employee Benefits & Payroll Taxes			872,498	872,498		872,498		872,498			22
23	Inservice Training & Education											23
24	Travel and Seminar			32,323	32,323		32,323		32,323			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			134,919	134,919		134,919		134,919			26
27	Other (specify):*											27
28	**TOTAL General Administration**	323,948	30,931	1,881,973	2,236,852		2,236,852	(147,465)	2,089,387			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,544,061	475,909	2,660,615	7,680,585		7,680,585	(171,113)	7,509,472			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:** 02/01/14 **Ending:** 01/31/2015

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			674,119	674,119		674,119	(102,489)	571,630			30
31	Amortization of Pre-Op. & Org.			17,563	17,563		17,563		17,563			31
32	Interest			623,573	623,573		623,573	(232,079)	391,494			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			259	259		259		259			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,315,514	1,315,514		1,315,514	(334,568)	980,946			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		254,882	724,736	979,618		979,618		979,618			39
40	Barber and Beauty Shops			19,980	19,980		19,980		19,980			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			219,754	219,754		219,754		219,754			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		254,882	964,470	1,219,352		1,219,352		1,219,352			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,544,061	730,791	4,940,599	10,215,451		10,215,451	(505,681)	9,709,770			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: 02/01/14 Ending: 01/31/2015

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	(2,831)	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	(102,489)	30		9
10	Interest and Other Investment Income	(232,079)	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	(922)	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	47,958	21		24
25	Fund Raising, Advertising and Promotional	(27,078)	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 See 5A	(178,407)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (495,848)		$	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)	(9,833)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (9,833)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (505,681)		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: 02/01/14

Ending: 01/31/2015

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Transportation Revenue	$ (5,327)	12	1
2	Transfer Temp Restr For Oper	(1,925)	21	2
3	Guest Apartment Revenue	(1,640)	06	3
4	Other Operating Income	(145)	21	4
5	Intercampus Revenue	(152,320)	21	5
6	Procurement Rebates	(13,562)	01	6
7	Maintenance Service	(288)	06	7
8	Non-Allowable Legal	(3,200)	19	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**	(178,407)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 **Report Period Beginning:** 02/01/14 **Ending:** 01/31/2015

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(13,562)	0	0	0	0	0	0	0	0	0	0	(13,562)	1
2	Food Purchase	(2,831)	0	0	0	0	0	0	0	0	0	0	(2,831)	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	(1,928)	0	0	0	0	0	0	0	0	0	0	(1,928)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18,321)	0	0	0	0	0	0	0	0	0	0	(18,321)	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	(5,327)	0	0	0	0	0	0	0	0	0	0	(5,327)	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 Program**	(5,327)	0	0	0	0	0	0	0	0	0	0	(5,327)	16
	C. General Administration													
17	Administrative	0	(471,540)	0	0	0	0	0	0	0	0	0	(471,540)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,200)	0	0	0	0	0	0	0	0	0	0	(3,200)	19
20	Fees, Subscriptions & Promotions	(27,078)	0	0	0	0	0	0	0	0	0	0	(27,078)	20
21	Clerical & General Office Expenses	(107,354)	461,707	0	0	0	0	0	0	0	0	0	354,353	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	0	0	0	0	0	0	0	0	0	0	0	0	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**	(137,632)	(9,833)	0	0	0	0	0	0	0	0	0	(147,465)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(161,280)	(9,833)	0	0	0	0	0	0	0	0	0	(171,113)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 **Report Period Beginning:** 02/01/14 **Ending:** 01/31/2015

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(102,489)	0	0	0	0	0	0	0	0	0	0	(102,489)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(232,079)	0	0	0	0	0	0	0	0	0	0	(232,079)	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**	(334,568)	0	0	0	0	0	0	0	0	0	0	(334,568)	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)**	(495,848)	(9,833)	0	0	0	0	0	0	0	0	0	(505,681)	45

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

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. ☐ 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		$ 685,563	$ 685,563	1
2	V	21	Other Operating Expense	25,920	Covenant Retirement Communities			(25,920)	2
3	V	21	Consultant Services	82,200	Covenant Retirement Communities			(82,200)	3
4	V	21	In Service Fees- Software	78,708	Covenant Retirement Communities			(78,708)	4
5	V	21	Legal Services	5,208	Covenant Retirement Communities			(5,208)	5
6	V	17	Management Service Fees	471,540	Covenant Retirement Communities			(471,540)	6
7	V	21	Payroll Services	31,820	Covenant Retirement Communities			(31,820)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 695,396			$ 685,563	$ * (9,833)	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: 02/01/14 Ending: 01/31/2015

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: 02/01/14 Ending: 01/31/2015

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: 02/01/14 Ending: 1/31/2015

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			$	$		$ 685,563	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					$	$		$ 685,563	25

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

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			$	$ 246,091			$ 12,712	1
2	2012A CO TX Bonds		X	Refinance Debt				10,236,505			507,871	2
3	2012C CO TX Bonds		X	Refinance Debt				2,053,291			102,990	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 12,535,887			$ 623,573	9
	B. Non-Facility Related*											
10	Interest Income										(232,079)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (232,079)	14
15	TOTALS (line 9+line14)						$	$ 12,535,887			$ 391,494	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: 02/01/14 Ending: 01/31/2015

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 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 2015 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:			
	2010		8
	2011		9
	2012		10
	2013		11
	2014		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 2014	$	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.

2014 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 2014 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 2014.

	(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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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: 02/01/14 Ending: 01/31/2015

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: 02/01/14 Ending: 01/31/2015

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				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			1992	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				24
25	Various			1996	9,674		20	483	483	9,191	25
26	Various			1997	4,570		20	229	229	4,597	26
27	Various			1998	5,750		20	288	288	5,118	27
28	Various			1999	5,092		20	255	255	4,335	28
29	Various			2000	9,810		20	491	491	7,614	29
30	Various			2001	1,541		20	77	77	1,493	30
31	Various			2004	8,747,969		20	437,398	437,398	4,811,459	31
32	Various			2005	20,996		20	1,050	1,050	447,896	32
33	Various			2008	126,294		20	6,315	6,315	45,254	33
34				2009	56,450			2,823	2,823	23,251	34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

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	$ 5,550	37
38	Lighting Improvement	2010	22,280		20	1,114	1,114	6,684	38
39	Automatic Trash Doors	2010	5,077		20	254	254	1,524	39
40	Therapy Heater	2010	4,273		20	214	214	1,284	40
41	Safety Barrier	2010	15,000		20	750	750	4,500	41
42	Vertical Shaft	2010	28,360		20	1,418	1,418	8,508	42
43	237 Cabinets	2010	3,356		20	168	168	1,008	43
44	Mhc Chiller Repair	2010	3,642		20	182	182	1,092	44
45	Mhc Compressor Repair	2010	4,483		20	224	224	1,344	45
46	Mhc Chiller Repair	2010	2,919		20	146	146	876	46
47	Mhc Soil Application	2010	6,584		20	329	329	1,974	47
48	Ccs Painting	2010	2,868		20	143	143	858	48
49	Hobart Disposer	2011	3,555		20	178	178	552	49
50	2Nd Floor Mhc Shower	2011	5,886		20	294	294	911	50
51	Mhc - Walk- In Freezer	2011	79,330		20	3,967	3,967	15,868	51
52	Courtyard Door Latch	2012	2,921		20	146	146	438	52
53	MHC South Exit Door	2012	5,286		20	264	264	792	53
54	MHC 2nd Fl. Corridor Remodel- Flooring, Wall Finishes/Paint,								54
55	Electrical Fixtures	2012	49,081		20	2,454	2,454	7,362	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	14,853	57
58	Dining Room Blinds	2013	3,033		20	152	152	304	58
59	Stairwell Railing- LSC Compliance Tag K034	2013	9,081		20	454	454	908	59
60	Patient Room Detection Lighting	2013	5,045		20	252	252	504	60
61	MHC Cross Corridor Smoke Barrier Detector System-	2014	19,569		20	489	489	978	61
62	LSC Compliance Tag K024- First Floor Cooridor Northwest section of Building								62
63									63
64	MHC Lobby ADA Accessible Reception Desk-Private Mtg Space	2014	154,098		20	3,852	3,852	7,705	64
65	(Steel Framing, drywall, electrical, ceiling tiles, carpet light fixtures, paint, quartz countertop and Adjustments to fire suppression sysetm.								65
66									66
67									67
68	Financial Statement Depreciation			674,119			(674,119)		68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,391,858	$ 674,119		$ 472,729	$ (201,390)	$ 5,446,585	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: 02/01/14 Ending: 01/31/2015

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	$ 986,646	$	$ 98,665	$ 98,665	10	$ 554,243	71
72	Current Year Purchases	4,717		236	236	10	236	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 991,363	$	$ 98,901	$ 98,901		$ 554,479	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)	$ 13,468,979	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 674,119	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 571,630	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (102,489)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,001,064	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: 02/01/14 Ending: 01/31/2015

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.	/2016	$
13.	/2017	$
14.	/2018	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO
16. Rental Amount for movable equipment: $ 259 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	831
Copier	-572
	259

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

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: 02/01/14 Ending: 01/31/2015

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-03	hrs	$		$ 248,030	$		$ 248,030	1
2	Licensed Speech and Language Development Therapist	39-03	hrs			108,665			108,665	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs			318,449			318,449	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				141,353		141,353	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					49,592	113,529		163,121	13
14	TOTAL			$		$ 724,736	$ 254,882		$ 979,618	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
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	Special Services - Supplies (Column 6 - Other)	Amount
13A	Nursing & Med Supp	109,707
13B	Equipment Rental/Repairs	3,822
13C		
13D		
13E		
13F		
13G		
13H		
13I		
13J		
		113,529

	Special Services - Outside (Column 5 - Other)	Amount
13K	Laboratory and X-Ray (Lax) Exp	34,863
13L	Oxygen (Oxy) Expense	14,729
13M		
13N		
13O		
13P		
13Q		
13R		
13S		
13T		
		49,592

	Special Services - Outside (Column 5 - Other)	Amount
13U		
13V		
13W		
13X		

13Y

13Z

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia **#** 0025577 **Report Period Beginning:** 02/01/14 **Ending:** 01/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/2015 **(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	17,931		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 18,681)	1,160,358		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	9,646		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	174,292		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,362,377	$	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	11,933,039		14
15	Leasehold Improvements, at Historical Cost	14,190		15
16	Equipment, at Historical Cost	803,730		16
17	Accumulated Depreciation (book methods)	(9,174,127)		17
18	Deferred Charges	169,242		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	7,449,986		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,281,818	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,644,195	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 95,389	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	365,530		29
30	Accrued Salaries Payable	322,653		30
31	Accrued Taxes Payable (excluding real estate taxes)	57,004		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	101,226		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached	257,702		36
37	See attached	398,919		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,598,423	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	12,170,357		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)**	$ 12,170,357	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 13,768,780	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,124,585)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,644,195	$	48

***(See instructions.)**

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	Other Current Assets:	Amount
09A	Other-ACC INT DEBT SERVICE RESERVES	9,880.00
09B	Other-BOND SINKING FUND	64,043.00
09C	Other-BOND INTEREST FUND	100,369.00
09D		
09E		
09F		
09G		
		174,292

	Other Non-Current Assets:	Amount
23A	Benevolent Care Fund	237,806
23B	Property Replacement Fund	3,820
23C	Capital Reserve Fund	90,257
23D	Debt Service Reserve Fund	1,274,107
23E	Asset Clearing	-
23F	Original Issue Discount (OID), Net	20,867
23G	Admin - Zone 91	5,823,129
		7,449,986

	Other Current Liabilities:	Amount
36A	Other-RESIDENT TRUST FUNDS	(17,931.00)
36B	Other-OTHER CURRENT LIABILITIES	(238,499.00)
36C	Design Contributions-General	0.00
36D	Other-DESIGN CONTRIBUTIONS-PROJECT 1	(1,272.00)
36E		
36F		
36G		
		(257,702)

	Other Current Liabilities	Amount
37A	Other-ORIGINAL ISSUE PREMIUM (OIP)	(525,091.00)
37B	Other-ACCUMULATED ACCRETION - OIP	126,172.00

37C		
37D		
37E		
37F		
37G		(398,919)

	Other Non-Current Liabilities:	Amount
43A		
43B		
43C		
43D		
43E		
43F		
43G		

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (947,249)	1
2	Restatements (describe):		2
3	**Rounding**	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (947,250)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(177,336)	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)	1	15
16	Other (describe) **Rounding**		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (177,335)	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)**	$ (1,124,585)	24 *

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

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

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	$ 10,800,658	1
2	Discounts and Allowances for all Levels	(2,902,571)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,898,087	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,173,753	6
7	Oxygen	24,320	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,198,073	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	27,099	13
14	Non-Patient Meals	2,831	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,640	16
17	Sale of Drugs	147,419	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	39,134	19
20	Radiology and X-Ray		20
21	Other Medical Services	220,662	21
22	Laundry	71,198	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 509,983	23
	D. Non-Operating Revenue		
24	Contributions	922	24
25	Interest and Other Investment Income***	269,989	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 270,911	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	161,061	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 161,061	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,038,115	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,683,117	31
32	Health Care	3,760,616	32
33	General Administration	2,236,852	33
	B. Capital Expense		
34	Ownership	1,315,514	34
	C. Ancillary Expense		
35	Special Cost Centers	999,598	35
36	Provider Participation Fee	219,754	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,215,451	40
41	**Income before Income Taxes (line 30 minus line 40)****	(177,336)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (177,336)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,558,482	44
45	Private Pay - Net Inpatient Revenue	5,000,754	45
46	Medicare - Net Inpatient Revenue	1,053,357	46
47	Other-(specify) Managed Care	285,494	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,898,087	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	
28A	Other-TRANSPORTATION REVENUE	(5,327.00)	Adj on 5a
28B	Other-MAINTENANCE SERVICES	(288.00)	Adj on 5a
28C	Other-TRANSFER TEMP RESTR FOR OPER	(1,925.00)	Adj on 5a
28D	Other-OTHER OPERATING INCOME	(145.00)	Adj on 5a
28E	Other-INVESTMENT PROPERTY REVENUE	(1,056.00)	
28F	Other-INTERCAMPUS REVENUE	(152,320.00)	Adj on 5a
		(161,061.00)	

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

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	1,032	1,073	$ 52,936	$ 49.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	40,642	43,591	1,493,406	34.26	3
4	Licensed Practical Nurses	4,737	5,140	153,603	29.88	4
5	CNAs & Orderlies	75,150	82,840	1,356,581	16.38	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,036	2,160	38,446	17.80	9
10	Activity Assistants	5,822	6,136	89,298	14.55	10
11	Social Service Workers	8,020	9,066	236,759	26.12	11
12	Dietician					12
13	Food Service Supervisor	2,057	2,265	47,884	21.14	13
14	Head Cook	7,374	7,860	119,290	15.18	14
15	Cook Helpers/Assistants	16,398	17,448	194,143	11.13	15
16	Dishwashers					16
17	Maintenance Workers	12,384	13,614	244,890	17.99	17
18	Housekeepers	8,201	9,147	102,148	11.17	18
19	Laundry	3,935	4,415	57,273	12.97	19
20	Administrator	1,715	1,932	108,542	56.18	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,353	10,237	215,406	21.04	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	1,430	1,694	33,456	19.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	200,286	218,618	$ 4,544,061 *	$ 20.79	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	11,000	09-03	36
37	Medical Records Consultant	8	1,536	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,726	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	10	2,478	11-03	44
45	Social Service Consultant	12	792	12-03	45
46	Other(specify)				46
47	Marketing Consultant	Monthly	600	20-03	47
48					48
49	TOTAL (lines 35 - 48)	30	$ 23,132		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,282	$ 122,340	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,423	65,985	10-03	52
53	TOTAL (lines 50 - 52)	2,705	$ 188,325		53

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	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Fundraising				
Marketing				

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Marya Jordan	Administrator	0	$ 108,542
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,542

B. Administrative - Other

Description	Amount
Covenant Retirement Communities - Management Fees	$ 471,540
TOTAL (agree to Schedule V, line 17, col. 3)	$ 471,540
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FGMK	Accounting	$ 4,546
FR&R	Mock Survey	546
Holleran Consulting	Staff Satifaction Survey	4,525
Jeremy Brune	Accounting	2,200
Mix Solutions	MCO Contacts	6,600
Mcgladrey	Accounting Consulting	1,550
Polsinelli	Legal	22,060
CSC	Legal	180
Plante Moran	Audit	12,648
NF and Assoc.	Executive coaching	7,228
TDF Rescources	Executive coaching	964
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 63,047

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,580
Unemployment Compensation Insurance	37,675
FICA Taxes	332,486
Employee Health Insurance	268,142
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403 B Matching	30,136
Group Life Insurance	8,505
Pension Plan	72,264
Physicals, Tuition, Other	22,251
Uniforms	1,459
TOTAL (agree to Schedule V, line 22, col.8)	$ 872,498

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	19,490
Health Care Worker Background Check	9,317
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	8,807
Public Relations	5,060
Advertising	22,018
Licenses and Permits	403
Less: Public Relations Expense	(5,060)
Non-allowable advertising	(22,018)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 40,007

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	24,485
Seminar Expense	7,838
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 32,323

* Attach copy of IMRF notifications

**See instructions.

CVOB
0025577
Legal Schedule
02/01/2014-01/31/2015

Date	Vendor	Amount	ADJ	Allowable
1/31/2015	Polsinelli	25,616.00	(3,200.00)	22,416.00
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
		$ 25,616.00	$ (3,200.00)	$22,416.00

Covenant Health Care - Batavia
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Seminar Schedule
02/01/14-01/31/15

AcctDesc.	Unit	Acct	Date/Description	DR	CR
CONFERENCES AND SEMINARS	4141	Activities	05 06/30/14 GL N 21 Klockars,	40	
CONFERENCES AND SEMINARS	4150	Dining Servi	01 02/28/14 GL N 15 Jordan, M	25	
CONFERENCES AND SEMINARS	4150	Dining Services			
CONFERENCES AND SEMINARS	4180	Administrati	01 02/28/14 GL N 15 Jordan, M	125	
CONFERENCES AND SEMINARS	4180	Administrati	02 03/12/14 AP I 1910083 2158	2,323	
CONFERENCES AND SEMINARS	4180	Administrati	02 03/20/14 AP I 1910089 2159	1,844	
CONFERENCES AND SEMINARS	4180	Administrati	05 06/30/14 GL N 21 Jordan, M	99	
CONFERENCES AND SEMINARS	4180	Administrati	06 07/31/14 AP I 1910143 5653	303	
CONFERENCES AND SEMINARS	4180	Administrati	07 08/31/14 GL N 34 Willow C	688	
CONFERENCES AND SEMINARS	4180	Administrati	11 12/31/14 GL N 17 Jordan, M	141	
CONFERENCES AND SEMINARS	4180	Administrati	11 12/31/14 GL N 17 Jordan, M	99	
CONFERENCES AND SEMINARS	4180	Administrati	12 01/31/15 GL N 27 Jordan, M	458	
TRAINING	4140	Nursing	02 03/14/14 AP I 1910128 2198	90	
TRAINING	4140	Nursing	03 04/11/14 AP I 1910107 2198	90	
TRAINING	4140	Nursing	03 04/11/14 AP I 1910107 2198	90	
TRAINING	4140	Nursing	04 05/19/14 AP I 1910207 2198	90	
TRAINING	4140	Nursing	06 07/31/14 GL N 17 Jordan, M	79	
TRAINING	4140	Nursing	08 09/30/14 AP I 1910361 2198	90	
TRAINING	4140	Nursing	09 10/26/14 AP I 1910296 2198	90	
TRAINING	4140	Nursing	10 11/30/14 AP I 1910273 2198	90	
TRAINING	4140	Nursing			
TRAINING	4141	Activities	11 12/31/14 GL N 17 Jordan, M	179	
TRAINING	4150	Dining Servi	06 07/31/14 GL N 17 Shaeffer,	36	
TRAINING	4150	Dining Servi	06 07/31/14 GL N 17 Shaeffer,	36	
TRAINING	4150	Dining Servi	07 08/31/14 AP I 1910298 2248	12	
TRAINING	4150	Dining Servi	07 08/31/14 GL N 23 Shaeffer,	25	
TRAINING	4150	Dining Servi	07 08/31/14 GL N 23 Shaeffer,	36	
TRAINING	4150	Dining Servi	09 10/31/14 AP I 1910301 2248	7	
TRAINING	4150	Dining Servi	11 12/01/14 AP I 1910011 5329	210	
TRAINING	4180	Administrati	05 06/24/14 AP I 1910189 2291	38	
TRAINING	4180	Administrati	06 07/07/14 AP I 1910102 2215	43	
TRAINING	4180	Administrati	06 07/31/14 AP I 1910257 5611	10	
TRAINING	4180	Administrati	07 08/31/14 GL N 23 Sanchez,	112	

TRAINING	4180	Administrati	08	09/30/14	AP I	1910200		425		36
TRAINING	4180	Administrati	09	10/31/14	GL N		29	Nothnag		10
TRAINING	4180	Administrati	09	10/31/14	GL N		29	Nothnag		26
TRAINING	4180	Administrati	09	10/31/14	GL N		29	Nothnag		29
TRAINING	4180	Administrati	10	11/01/14	AP I	1910079		486		125
TRAINING	4180	Administrati	12	01/31/15	AP I	1910391		425		16
										7,838

Covenant Health Care - Batavia
0025577
Travel Schedule
02/01/14-01/31/15

Acct#	Description	Amount
4140-4701-0	Nursing-TRAVEL AND AUTO	16,371.00
4141-4701-0	Activities-TRAVEL AND AUTO	35.00
4142-4701-0	Chaplains-TRAVEL AND AUTO	1,296.00
4144-4701-0	Transportation-TRAVEL AND AUTO	4,418.00
4149-4701-0	Other Resident Benefits-TRAVEL AND AUTO	12.00
4150-4701-0	Dining Services-TRAVEL AND AUTO	268.00
4180-4701-0	Administrative and General-TRAVEL AND AUTO	2,085.00
		24,485.00

Facility Name & ID Number Covenant Hlth Cr Ctr Batavia # 0025577 Report Period Beginning: 02/01/14 Ending: 01/31/2015

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: 02/01/14 Ending: 01/31/2015

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/AAHSA $6,508**

(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. $ **53,607** 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. $ **219,754**
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. $ **2,831**

(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 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.