

		FOR BHF USE					

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2006
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2006)

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

I. IDPH Facility ID Number: 0033779

Facility Name: Covenant Health Care Center-Northbrook

Address: 2155 Pfingsten Road Northbrook 60062
 Number City Zip Code

County: Cook

Telephone Number: 847-480-6390 **Fax #** 847-480-7666

HFS ID Number: 52115873001

Date of Initial License for Current Owners: 01/20/72

Type of Ownership:

<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other _____	

In the event there are further questions about this report, please contact:
Name: Linda Davis **Telephone Number:** 773-878-2295 Ext 826

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 02-01-2005 to 01-31-2006 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) <u>Elizabeth Buikema</u>	
	(Title) <u>Vice President / CFO</u>	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) _____	
	(Firm Name & Address) _____	
	(Telephone) () _____ Fax # () _____	

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 Health Care Center-Northbrook

0033779 Report Period Beginning: 02-01-2005 Ending: 01-31-2006

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 _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	102	Skilled (SNF)	102	37,230	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	64	23,360	5
6		ICF/DD 16 or Less			6
7	166	TOTALS	166	60,590	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	9,845	22,398	2,652	34,895	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	18,090			18,090	12
13	DD 16 OR LESS					13
14	TOTALS	27,935	22,398	2,652	52,985	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.45%

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)

Meals on wheels

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 012072

J. Was the facility purchased or leased after January 1, 1978?

YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 102 and days of care provided 2,652

Medicare Intermediary AdminisStar Federal

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 01312006 Fiscal Year: 01312006

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

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02-01-2005 Ending: 01-31-2006

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	528,222	84,602	6,985	619,809		619,809	(16,104)	603,705			1
2	Food Purchase		429,153		429,153		429,153		429,153			2
3	Housekeeping	235,860	38,886	2,248	276,994		276,994		276,994			3
4	Laundry		14,270	120,595	134,865		134,865		134,865			4
5	Heat and Other Utilities			195,586	195,586		195,586		195,586			5
6	Maintenance	121,834	69,547	261,233	452,614		452,614		452,614			6
7	Other (specify):*											7
8	TOTAL General Services	885,916	636,458	586,647	2,109,021		2,109,021	(16,104)	2,092,917			8
	B. Health Care and Programs											
9	Medical Director			24,869	24,869		24,869		24,869			9
10	Nursing and Medical Records	2,805,904	167,219	75,358	3,048,481		3,048,481		3,048,481			10
10a	Therapy											10a
11	Activities	186,760	11,570	3,702	202,032		202,032		202,032			11
12	Social Services	120,036	18,322		138,358		138,358		138,358			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,112,700	197,111	103,929	3,413,740		3,413,740		3,413,740			16
	C. General Administration											
17	Administrative	137,588		431,340	568,928		568,928		568,928			17
18	Directors Fees											18
19	Professional Services			80,790	80,790		80,790		80,790			19
20	Dues, Fees, Subscriptions & Promotions			43,051	43,051		43,051	(18,314)	24,737			20
21	Clerical & General Office Expenses	248,856	56,197	250,031	555,084		555,084	(260,596)	294,488			21
22	Employee Benefits & Payroll Taxes			1,121,524	1,121,524		1,121,524		1,121,524			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,217	6,217		6,217		6,217			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			219,244	219,244		219,244		219,244			26
27	Other (specify):*											27
28	TOTAL General Administration	386,444	56,197	2,152,197	2,594,838		2,594,838	(278,910)	2,315,928			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,385,060	889,766	2,842,773	8,117,599		8,117,599	(295,014)	7,822,585			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 Health Care Center-Northbrook #0033779 Report Period Beginning: 02-01-2005 Ending: 01-31-2006

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			480,051	480,051		480,051	480,051			30
31	Amortization of Pre-Op. & Org.										31
32	Interest			136,940	136,940		136,940	(136,940)			32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			616,991	616,991		616,991	(136,940)	480,051		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		513,433	267,398	780,831		780,831	780,831			39
40	Barber and Beauty Shops	47,801	1,667		49,468		49,468	49,468			40
41	Coffee and Gift Shops										41
42	Provider Participation Fee				55,845		55,845	55,845			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers	47,801	515,100	267,398	886,144		886,144	886,144			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,432,861	1,404,866	3,727,162	9,620,734		9,620,734	(431,954)	9,188,780		45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(136,940)	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				24
25	Fund Raising, Advertising and Promotional	(18,314)	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (155,254)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (155,254)		37

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

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

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

BHF USE ONLY						
48		49		50		51
						52

Covenant Health Care Center-Northbrook

ID# 0033779

Report Period Beginning: 02-01-2005

Ending: 01-31-2006

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Non allow Benevolent care expense	\$ (260,596)	21	1
2	Meal Income offset	(16,104)	1	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				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	(276,700)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Health Care Center-Northbrook

0033779

Report Period Beginning:

02-01-2005

Ending:

01-31-2006

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(16,104)	0	0	0	0	0	0	0	0	0	0	(16,104)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(16,104)	0	0	0	0	0	0	0	0	0	0	(16,104)	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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(18,314)	0	0	0	0	0	0	0	0	0	0	(18,314)	20
21	Clerical & General Office Expenses	(260,596)	0	0	0	0	0	0	0	0	0	0	(260,596)	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	(278,910)	0	0	0	0	0	0	0	0	0	0	(278,910)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(295,014)	0	0	0	0	0	0	0	0	0	0	(295,014)	29

STATE OF ILLINOIS

Facility Name & ID Number Covenant Health Care Center-Northbrook

0033779

Report Period Beginning:

02-01-2005 Ending:

Summary B

01-31-2006

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

	Capital Expense	PAGES	PAGE	SUMMARY										
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(136,940)	0	0	0	0	0	0	0	0	0	0	(136,940)	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	(136,940)	0	(136,940)	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)	(431,954)	0	(431,954)	45									

Facility Name & ID Number Covenant Health Care Center-Northbrook

0033779

Report Period Beginning: 02-01-2005 Ending: 01-31-2006

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V		\$			\$	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$			\$	\$ *	14

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

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02-01-2005 Ending: 01-31-2006

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02-01-2005 Ending: 1-31-2006

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Covenant Retirement Communities
 Street Address 5115 N. Francisco Ave
 City / State / Zip Code Chicago, Illinois 60625
 Phone Number (773-878-2294
 Fax Number (773-878-2289

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Management Fees	Net Service Revenue	49	\$ 9,828,823	\$ 2,821,747		\$ 431,340	1
2	19	Data Processing	Fixed Fee per Month	49	646,021			17,688	2
3	19	Auditing Services	Fixed Fee per Month	49	435,579			30,000	3
4	19	Cost Report Prep	Fixed Fee per Month	14	56,016			5,748	4
5	19	Payroll Services	Direct Cost	1	19,647			19,647	5
6	22	Pension Plan	Direct Cost	1	177,384			177,384	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				\$ 11,163,470	\$ 2,821,747		\$ 681,807	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
A. Directly Facility Related																				
Long-Term																				
1	1998 TE Term bond		x		1/98	\$	\$	12/1/2015	variable	\$ 34,398	1									
2	1998 TE Term bond		x		1/98			12/1/2015	variable	4,797	2									
3	2002 Tax EX Bond		x		1/2002			12/1/2015	variable	197,151	3									
4											4									
5											5									
Working Capital																				
6	CRC Interco Notes									(99,406)	6									
7											7									
8											8									
9	TOTAL Facility Related					\$	\$			\$ 136,940	9									
B. Non-Facility Related*																				
10	Adjust Interest income									(136,940)	10									
11											11									
12											12									
13											13									
14	TOTAL Non-Facility Related					\$	\$			\$ (136,940)	14									
15	TOTALS (line 9+line14)					\$	\$			\$	15									

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>																																					
1. Real Estate Tax accrual used on 2005 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 2006 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4																																		
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																																		
Real Estate Tax History:																																					
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>2001</td><td>_____</td><td>8</td></tr> <tr><td>2002</td><td>_____</td><td>9</td></tr> <tr><td>2003</td><td>_____</td><td>10</td></tr> <tr><td>2004</td><td>_____</td><td>11</td></tr> <tr><td>2005</td><td>_____</td><td>12</td></tr> </table>	2001	_____	8	2002	_____	9	2003	_____	10	2004	_____	11	2005	_____	12	<table border="1"> <tr><td colspan="2">FOR BHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2005</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>		FOR BHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2005	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
2001	_____	8																																			
2002	_____	9																																			
2003	_____	10																																			
2004	_____	11																																			
2005	_____	12																																			
FOR BHF USE ONLY																																					
13	FROM R. E. TAX STATEMENT FOR 2005	\$	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.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2005 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2005 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2005.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2005 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2006 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2005 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Health Care Center-Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033779

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE (____) _____ FAX #: (____) _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2005 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 2005.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
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 & 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 2005 tax bills which were listed in Section A to this statement. Be sure to use the 2005 tax bill which is normally paid during 2006.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 77,894 B. General Construction Type: Exterior Brick Masonary Frame Steel Studded Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

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

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

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1973	\$ 70,721	1
2					2
3	TOTALS			\$ 70,721	3

Facility Name & ID Number Covenant Health Care Center-Northbrook

0033779

Report Period Beginning:

02-01-2005 Ending: 01-31-2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-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	166		1974	1974	\$ 1,467,406	\$		\$	\$	\$	4
5			1975	1975	2,250						5
6			1976	1976	1,916						6
7			1977	1977	2,769						7
8			1978	1978	7,643						8
	Improvement Type**										
9		Building Improvements Brandel Care Ctr		1979	18,220						9
10		Building Improvements Brandel Care Ctr		1980	20,844						10
11		Building Improvements Brandel Care Ctr		1981	38,116						11
12		Building Improvements Brandel Care Ctr		1982	3,360						12
13		Building Improvements Brandel Care Ctr		1984	13,999						13
14		Building Improvements Brandel Care Ctr		1985	162,076						14
15		Building Improvements Brandel Care Ctr		1986	36,791						15
16		Building Improvements Brandel Care Ctr		1987	17,303						16
17		Building Improvements Brandel Care Ctr		1988	30,032						17
18		Building Improvements Brandel Care Ctr		1989	472,871						18
19		Building Improvements Brandel Care Ctr		1989	115,230						19
20		Building Improvements Brandel Care Ctr		1990	77,922						20
21		Building Improvements Brandel Care Ctr		1991	25,051						21
22		Building Improvements Brandel Care Ctr		1992	7,901						22
23		Building Improvements Brandel Care Ctr		1994	19,938						23
24		52 Pair of shear and rods all pat ttoom		1997	8,000						24
25		14 cubic curtains-wings 100 & 200		1997	2,636						25
26		A/C equipment		1998	3,549						26
27		Room Remodeling		1999	2,989						27
28		Window Treatments		1999	29,864						28
29		Heating A/C work		1999	1,665						29
30		New light fixtures		1999	1,647						30
31		Hall door replacement		1999	329						31
32		Roof repair		1999	133,950						32
33		New bathrooms		2000	9,685						33
34		Renovation/modernization-consulting fees design		2000	39,980						34
35		architectural fee		2000	41,630						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 Health Care Center-Northbrook

0033779

Report Period Beginning:

02-01-2005 Ending:

01-31-2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Development cost	2000	\$ 41,531	\$	20	\$	\$	\$	37
38	renovation/modernization primary architect fees	2000	278,453		20				38
39	inspection testing fees	2000	3,143		20				39
40	architect/engineering-	2000	3,615		20				40
41	building permits	2000	33,347		20				41
42	mis city count state fees	2000	9,775		20				42
43	village of northbrookfes	2000	80		20				43
44	legal	2000	32,405		20				44
45	site work	2000	180,808		20				45
46	foundation /slab	2000	94,988		20				46
47	building costs	2000	2,875,182		20				47
48	job services	2000	364,637		20				48
49	other	2000	13,693		20				49
50	alarm units	2000	2,204		20				50
51	construction fee	2000	69,822		20				51
52	remodel wings 200 and 400	2001	123,129		20				52
53	closed circuit tv monitoring system	2003	5,576		20				53
54	remodel residents room 400 wing	2003	16,375		20				54
55	new hot water boiler for Brandel	2004	29,187		20				55
56	resident roomdoor replacement	2004	48,247		20				56
57	painting cooridars	2005	17,390		20				57
58	Brandel Land improvements	1982	372,026						58
59	Brandel Land improvements	1985	40,541						59
60	Brandel Land improvements	1987	665						60
61	Brandel Land improvements	1989	1,500						61
62	Axelson Land improvement	2006	8,425			529	529	1,852	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,484,306	\$		\$ 529	\$ 529	\$ 1,852	70

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

Facility Name & ID Number Covenant Health Care Center-Northbrook

0033779

Report Period Beginning:

02-01-2005

Ending:

01-31-2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,484,306	\$		\$ 529	\$ 529	\$ 1,852	1
2	Building improvements Axelson Manor	1987	9,537						2
3	Building improvements Axelson Manor	1988	11,898						3
4	Building improvements Axelson Manor	1989	25,256						4
5	Building improvements Axelson Manor	1990	6,612						5
6	Building improvements Axelson Manor	1991	5,581						6
7	Building improvements Axelson Manor	1992	10,312						7
8	Building improvements Axelson Manor	1993	10,084						8
9	Building improvements Axelson Manor	1994	11,446						9
10	Building improvements Axelson Manor	1995	4,965						10
11	Padding and carpet	1996	3,410						11
12	Drapes and sheers	1996	1,857						12
13	Carpet	1997	11,718						13
14	Food Service renovation	1997	5,951						14
15	New Building consulting fees, design & concept phase	1998	17,722						15
16	property concept development costs	1998	13,384						16
17	primary architect fees	1998	179,191						17
18	collabortive architect rep fee	1998	215						18
19	inspection testing fee	1998	1,701						19
20	architect and engineering	1998	2,675						20
21	building permits	1998	15,955						21
22	city county state fees	1998	2,221						22
23	fees and permits	1998	40						23
24	legal	1998	4,147						24
25	site work	1988	171,849						25
26	foundation slab	1998	112,341						26
27	construction costs	1998	1,309,646						27
28	job services	1998	173,015						28
29	construction fee	1998	38,797						29
30	new building construction	1998	10,890						30
31	other	1998	6,480						31
32	carpet	1998	6,817						32
33	draoes sheers	1999	554						33
34	TOTAL (lines 1 thru 33)		\$ 9,670,573	\$		\$ 529	\$ 529	\$ 1,852	34

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

Facility Name & ID Number Covenant Health Care Center-Northbrook

0033779

Report Period Beginning:

02-01-2005

Ending:

01-31-2006

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,670,573	\$		\$ 529	\$ 529	\$ 1,852	1
2	New roof	1999	38,000						2
3	additional construction architects fee	1999	2,416						3
4	construction costs	1999	69,907						4
5	floor covering	2000	3,308						5
6	remodel patio entrance	2001	20,000						6
7	carpet replacement common areas	2001	2,665						7
8	drapery replacement common area	2001	269						8
9	paving entrance parking lot	2001	36,342						9
10	remodel patio entrance	2001	8,547						10
11	remodel patio entrance	2001	940						11
12	remodel patio entrance	2001	20,697						12
13	remodel patio entrance	2001	4,575						13
14	remodel patio entrance	2002	21,111						14
15	remodel resident bathrooms	2003	13,609						15
16	carpet replacement	2003	44,098						16
17	A/C work	2003	6,484						17
18	electrical work activites room	2003	1,467						18
19	remodel fountain area	2003	2,025						19
20	remodel residents bathrooms	2004	7,025						20
21	replace doors in resident rooms	2004	52,417						21
22	remodel residents foorms	2004	14,609						22
23	painting residents room	2005	22,221						23
24	painting residents room	2005	8,932						24
25	Axelson Renovation	2006							25
26	Concept /Design	2006	18,102						26
27	Architects fee	2006	50,265						27
28	Permits	2006	6,000						28
29	Legal	2006	1,484						29
30	Building costs	2006	526,885						30
31	Brandel	2006	55,760			332,271	332,271	4,486,852	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,730,733	\$		\$ 332,800	\$ 332,800	\$ 4,488,704	34

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

Facility Name & ID Number Covenant Health Care Center-Northbrook # 0033779 Report Period Beginning: 02-01-2005 Ending: 01-31-2006

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 1,139,900	\$	\$ 130,840	\$ 130,840		\$ 696,828	71
72	Current Year Purchases	152,853						72
73	Fully Depreciated Assets	(39,099)						73
74								74
75	TOTALS	\$ 1,253,654	\$	\$ 130,840	\$ 130,840		\$ 696,828	75

D. Vehicle Depreciation (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	Van	2000	2000	\$ 14,034	\$	\$	\$		\$ 14,034	76
77										77
78										78
79										79
80	TOTALS			\$ 14,034	\$	\$	\$		\$ 14,034	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)	\$ 12,069,142	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 463,640	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 463,640	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 5,199,566	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

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

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.	_____ /2007	\$ _____
13.	_____ /2008	\$ _____
14.	_____ /2009	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(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.

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$	1,668	\$ 100,080	\$	1,668	\$ 100,080	1
2	Licensed Speech and Language Development Therapist		hrs		460	6,830		460	6,830	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs		2,674	160,486		2,674	160,486	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				513,433		513,433	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	4,802	\$ 267,396	\$ 513,433	4,802	\$ 780,829	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Covenant Health Care Center-Northbrook# 0033779Report Period Beginning: 02-01-2005

Ending:

01-31-2006**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of 01-31-2006

(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	\$ 39,651	\$ 12,477,000	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	426,386	50,347,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 466,037	\$ 62,824,000	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,329,386		12
13	Land	80,861		13
14	Buildings, at Historical Cost	12,531,682	389,739,000	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,197,827		16
17	Accumulated Depreciation (book methods)	(5,760,982)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		314,722,000	21
22	Other Long-Term Assets (specify):	7,084,372	31,438,000	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,463,146	\$ 735,899,000	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 16,929,183	\$ 798,723,000	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 39,415	\$ 117,048,000	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	483,385		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,578		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>intercompany notes</u>		421,576,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 557,378	\$ 538,624,000	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		151,020,00.00	39
40	Mortgage Payable			40
41	Bonds Payable	3,471,851		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		(7,014,360)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (3,542,509)	\$ 151,020,000	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (2,985,131)	\$ 689,644,000	46
47	TOTAL EQUITY(page 18, line 24)	\$ 19,914,314	\$ 109,079,000	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 16,929,183	\$ 798,723,000	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 18,947,377	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 18,947,378	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	966,936	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)	\$ 966,936	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)	\$ 19,914,314	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Covenant Health Care Center-Northbrook# 0033779Report Period Beginning: 02-01-2005Ending: 01-31-2006**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,651,464	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,651,464	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	653,000	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 653,000	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	92,254	13
14	Non-Patient Meals	16,104	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	563,834	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,500	19
20	Radiology and X-Ray		20
21	Other Medical Services	236,028	21
22	Laundry	75,897	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 985,617	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	297,588	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 297,588	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,587,669	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	2,109,021	31
32	Health Care	3,413,740	32
33	General Administration	2,594,838	33
B. Capital Expense			
34	Ownership	616,990	34
C. Ancillary Expense			
35	Special Cost Centers	830,299	35
36	Provider Participation Fee	55,845	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,620,733	40
41	Income before Income Taxes (line 30 minus line 40)**	966,936	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 966,936	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Covenant Health Care Center-Northbrook

0033779

Report Period Beginning: 02-01-2005

Ending:

01-31-2006

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,952	2,080	\$ 79,399	\$ 38.17	1
2	Assistant Director of Nursing	1,160	1,264	38,659	30.58	2
3	Registered Nurses	32,122	35,701	982,747	27.53	3
4	Licensed Practical Nurses	7,487	8,257	176,600	21.39	4
5	CNAs & Orderlies	100,236	113,634	1,488,409	13.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	12,474	13,639	186,760	13.69	10
11	Social Service Workers	5,785	6,224	120,036	19.29	11
12	Dietician					12
13	Food Service Supervisor	3,788	4,519	100,081	22.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	38,798	42,176	428,141	10.15	15
16	Dishwashers					16
17	Maintenance Workers	7,884	8,967	121,833	13.59	17
18	Housekeepers	16,619	18,726	235,860	12.60	18
19	Laundry					19
20	Administrator	3,457	3,838	137,588	35.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	15,038	16,446	248,855	15.13	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	1,881	2,082	40,165	19.29	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Beauty shop</u>	2,677	3,037	47,728	15.72	33
34	TOTAL (lines 1 - 33)	251,358	280,590	\$ 4,432,861 *	\$ 15.80	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	65	\$ 6,985	1-3	35
36	Medical Director	Monthly	24,869	9-3	36
37	Medical Records Consultant	Monthly	4,800	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,992	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	100	3,702	11-3	44
45	Social Service Consultant	120	1,285	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	285	\$ 43,633		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	1,045	68,137	10-3	52
53	TOTAL (lines 50 - 52)	1,045	\$ 68,137		53

Facility Name & ID Number Covenant Health Care Center-Northbrook

0033779

Report Period Beginning: 02-01-2005

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries			D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Jonathan Kasper	Administrator	none	\$ 74,064	Workers' Compensation Insurance	\$ 92,062	IDPH License Fee	\$	
Paul Peterson	Administrator	none	63,523	Unemployment Compensation Insurance	7,305	Advertising: Employee Recruitment	10,187	
				FICA Taxes	313,599	Health Care Worker Background Check	3,458	
				Employee Health Insurance	500,046	(Indicate # of checks performed)		
				Employee Meals		Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		LSN	5,463	
				Group Life Ins	14,225	Licenses and Permits		
				Pension Plan	177,384	Marketing	18,314	
				Other	16,902	Dues and subscriptions	5,629	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 137,587	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,121,523	TOTAL (agree to Sch. V, line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
CRC Management Service			\$ 431,340				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 431,340				Seminar Expense	
C. Professional Services								
Vendor/Payee	Type		Amount				Entertainment Expense	()
Deloitte & Touche	Audit Services		\$ 30,000				(agree to Sch. V, line 24, col. 8)	
Covenant Retirement	Data Processing		17,688				TOTAL	\$
Covenant Retirement	Cost Report Preparation		5,748					
ADP	Payroll Services		19,647					
Seabury & Smith	Benefit Consult		4,714					
FR&R	Healthcare consulting		2,993					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 80,790	TOTAL		\$		

* Attach copy of IMRF notifications

**See instructions.

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,5462.
- (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? _____
- (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? _____
- (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
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 52,670 Line _____
- (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. _____
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 55,845
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? _____ 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. \$ no Has any meal income been offset against related costs? yes Indicate the amount. \$ _____
- (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. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? none
- d. Have vehicle usage logs been maintained? yes
- 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? yes
- g. Does the facility transport residents to and from day training? no**
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? _____
Firm Name: Deloitte & Touche,LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? yes If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? na
Attach invoices and a summary of services for all architect and appraisal fees.