

		FOR BHF USE				

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

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.

<p>I. IDPH License ID Number: <u>0033779</u></p> <p>Facility Name: <u>Covenant Hlth Cr Ctr Nrthbrk</u></p> <p>Address: <u>2155 Pffingsten Road</u> <u>Northbrook</u> <u>60062</u> <small>Number City Zip Code</small></p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 480-6390</u> Fax # <u>(847) 480-7666</u></p> <p>HFS ID Number: _____</p> <p>Date of Initial License for Current Owners: <u>1/20/1972</u></p> <p>Type of Ownership:</p> <table style="width: 100%;"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Andrew Cutler</u> Telephone Number: <u>(847) 374-0400</u> Email Address: _____</p>	<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 _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>02/01/2014</u> to <u>01/31/2015</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1" style="width: 100%;"> <tr> <td style="width: 30%;">Officer or Administrator of Provider</td> <td>(Signed) _____ (Type or Print Name) _____ (Title) _____</td> </tr> <tr> <td>Paid Preparer</td> <td>(Signed) _____ (Date) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015</u> (Telephone) <u>(847) 374-0400</u> Fax: <u>(847) 374-0420</u></td> </tr> </table> <p>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</p>	Officer or Administrator of Provider	(Signed) _____ (Type or Print Name) _____ (Title) _____	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Andrew B. Cutler</u> <u>Managing Director</u> (Firm Name & Address) <u>FGMK, LLC</u> <u>2801 Lakeside Dr., 3rd Floor Bannockburn, IL 60015</u> (Telephone) <u>(847) 374-0400</u> Fax: <u>(847) 374-0420</u>
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Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk

0033779 Report Period Beginning: 02/01/2014 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	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		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	102	TOTALS	102	37,230	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5
		3 Medicaid Recipient	4 Private Pay	Other	Total	
8	SNF	7,488	15,705	6,615	29,808	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,488	15,705	6,615	29,808	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.06%

D. How many bed-hold days during this year were paid by the Department? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

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 01/20/1972

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 6,231

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 01/31 Fiscal Year: 01/31

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2014 Ending: 01/31/2015

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	299,558	10,091	44,394	354,043		354,043		354,043		1
2	Food Purchase		358,673		358,673		358,673	(5,718)	352,955		2
3	Housekeeping	128,599	25,218	7,577	161,394		161,394		161,394		3
4	Laundry	35,250	7,907	94,335	137,492		137,492		137,492		4
5	Heat and Other Utilities			155,447	155,447		155,447		155,447		5
6	Maintenance	107,491	32,839	195,507	335,837		335,837	(504)	335,333		6
7	Other (specify):*										7
8	TOTAL General Services	570,898	434,728	497,260	1,502,886		1,502,886	(6,222)	1,496,664		8
	B. Health Care and Programs										
9	Medical Director			53,280	53,280		53,280		53,280		9
10	Nursing and Medical Records	2,860,367	60,409	23,711	2,944,487		2,944,487		2,944,487		10
10a	Therapy										10a
11	Activities	202,704	2,540	26,691	231,935		231,935		231,935		11
12	Social Services	144,242		15,220	159,462		159,462	(6,284)	153,178		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,207,313	62,949	118,902	3,389,164		3,389,164	(6,284)	3,382,880		16
	C. General Administration										
17	Administrative	100,600		467,736	568,336		568,336	(467,736)	100,600		17
18	Directors Fees										18
19	Professional Services			52,274	52,274		52,274	(135,034)	(82,760)		19
20	Dues, Fees, Subscriptions & Promotions			129,715	129,715		129,715	(127,008)	2,707		20
21	Clerical & General Office Expenses	277,235		461,564	738,799		738,799	389,291	1,128,090		21
22	Employee Benefits & Payroll Taxes			936,461	936,461		936,461		936,461		22
23	Inservice Training & Education										23
24	Travel and Seminar			18,115	18,115		18,115		18,115		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			130,238	130,238		130,238		130,238		26
27	Other (specify):*										27
28	TOTAL General Administration	377,835		2,196,103	2,573,938		2,573,938	(340,487)	2,233,451		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,156,046	497,677	2,812,265	7,465,988		7,465,988	(352,993)	7,112,995		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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	D. Ownership										
30	Depreciation			511,141	511,141	511,141	31,673	542,814			30
31	Amortization of Pre-Op. & Org.			4,144	4,144	4,144		4,144			31
32	Interest			54,472	54,472	54,472	(54,472)				32
33	Real Estate Taxes										33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles			12,800	12,800	12,800		12,800			35
36	Other (specify):* Loss on Sale			33,010	33,010	33,010		33,010			36
37	TOTAL Ownership			615,567	615,567	615,567	(22,799)	592,768			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		408,247	799,147	1,207,394	1,207,394		1,207,394			39
40	Barber and Beauty Shops	18,914		1,711	20,625	20,625	(20,625)				40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			193,395	193,395	193,395		193,395			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers	18,914	408,247	994,253	1,421,414	1,421,414	(20,625)	1,400,789			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,174,960	905,924	4,422,085	9,502,969	9,502,969	(396,417)	9,106,552			45

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

VI. ADJUSTMENT DETAIL

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

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,718)	2		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	31,673	30		9
10	Interest and Other Investment Income	(54,472)	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	(146,910)	21		24
25	Fund Raising, Advertising and Promotional	(105,097)	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	(105,210)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (385,734)		\$	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	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)	(10,683)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (10,683)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (396,417)		37

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

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

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

Covenant Hlth Cr Ctr Nrthbrk

ID# 0033779

Report Period Beginning: 02/01/2014

Ending: 01/31/2015

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Barber and Beauty	\$ (20,625)	40	1
2	Guest Apartment Rental	(504)	06	2
3	Transportation Revenue	(6,284)	12	3
4	Transfer Temp Restr For Oper	(8,058)	21	4
5	Other Services Revenue	(34)	21	5
6	Other Operating Income	(5,812)	21	6
7	Intercampus Revenue	(39,795)	21	7
8	Investment Property Revenue	(2,031)	21	8
9	Income on Other	(156)	21	9
10	Fundraising Revenue	(21,911)	20	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	(105,210)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk# 0033779

Report Period Beginning:

02/01/2014

Ending:

01/31/2015

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(5,718)	0	0	0	0	0	0	0	0	0	0	(5,718)	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	(504)	0	0	0	0	0	0	0	0	0	0	(504)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(6,222)	0	0	0	0	0	0	0	0	0	0	(6,222)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(6,284)	0	0	0	0	0	0	0	0	0	0	(6,284)	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	(6,284)	0	0	0	0	0	0	0	0	0	0	(6,284)	16
	C. General Administration													
17	Administrative	0	(467,736)	0	0	0	0	0	0	0	0	0	(467,736)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(135,034)	0	0	0	0	0	0	0	0	0	(135,034)	19
20	Fees, Subscriptions & Promotions	(127,008)	0	0	0	0	0	0	0	0	0	0	(127,008)	20
21	Clerical & General Office Expenses	(202,796)	592,087	0	0	0	0	0	0	0	0	0	389,291	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	(329,804)	(10,683)	0	(340,487)	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(342,310)	(10,683)	0	(352,993)	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk# 0033779

Report Period Beginning:

02/01/2014 Ending:01/31/2015

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	31,673	0	0	0	0	0	0	0	0	0	0	31,673	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(54,472)	0	0	0	0	0	0	0	0	0	0	(54,472)	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	(22,799)	0	0	0	0	0	0	0	0	0	0	(22,799)	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	(20,625)	0	0	0	0	0	0	0	0	0	0	(20,625)	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	(20,625)	0	0	0	0	0	0	0	0	0	0	(20,625)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(385,734)	(10,683)	0	(396,417)	45								

VII. RELATED PARTIES

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

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

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	21	<u>Office Expense-CRC Alloc.</u>	<u>Covenant Retirement Communities</u>		\$	\$	641,347	1
2	V	21	<u>Other Operating Expense</u>	<u>Covenant Retirement Communities</u>				(12,204)	2
3	V	19	<u>Consultant Services</u>	<u>Covenant Retirement Communities</u>				(99,066)	3
4	V	21	<u>In Service Fees- Software</u>	<u>Covenant Retirement Communities</u>				(37,056)	4
5	V	19	<u>Legal Services</u>	<u>Covenant Retirement Communities</u>				(6,944)	5
6	V	17	<u>Management Service Fees</u>	<u>Covenant Retirement Communities</u>				(467,736)	6
7	V	19	<u>Payroll Services</u>	<u>Covenant Retirement Communities</u>				(29,024)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$ 652,030			\$	\$ *	(10,683)	14

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

Facility Name & ID Number

Covenant Hlth Cr Ctr Nrthbrk

0033779

Report Period Beginning:

02/01/2014

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

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

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

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk

0033779

Report Period Beginning: 02/01/2014

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 NO

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

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

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		\$	\$		\$ 641,347	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				\$	\$		\$ 641,347	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	Name of Lender	2		3	4	5	6		8	9	10						
		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	2012C Col Tax Ex Bonds		X	Capital Improvements		2012	\$	\$ 805,033			\$ 42,455	1					
2	2012A Col Tax Ex Bonds		X	Capital Improvements		2012		539,199			25,410	2					
3												3					
4												4					
5												5					
Working Capital																	
6												6					
7												7					
8												8					
9	TOTAL Facility Related						\$	\$ 1,344,232			\$ 67,865	9					
B. Non-Facility Related*																	
10	Accretion of OIP		X								(14,581)	10					
11	Financing Assessment		X								1,188	11					
12	Interest Adjustment										(54,472)	12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ (67,865)	14					
15	TOTALS (line 9+line14)						\$	\$ 1,344,232			\$	15					

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

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

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

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

B. Real Estate Taxes

<p>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</p>			
1. Real Estate Tax accrual used on 2014 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 Nrthbrk COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033779

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)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 77,894 B. General Construction Type: Exterior Brick Masonry 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: 25,168 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: 4,144 4. Dates Incurred: _____

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

XI. OWNERSHIP COSTS:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1973</u>	<u>\$ 70,721</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 70,721	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	102	1974	1974	\$ 1,467,409	\$	40	\$	\$	\$ 1,467,409	4
5		1975	1975	2,250		40	56	56	2,248	5
6		1976	1976	1,916		40	48	48	1,869	6
7		1977	1977	2,769		40	69	69	2,629	7
8		1978	1978	7,643		40	191	191	7,069	8
Improvement Type**										
9	Various		1979	18,220		20			18,220	9
10	Various		1980	20,844		20			20,844	10
11	Various		1981	38,116		20			38,116	11
12	Various		1982	17,734		20			1,709,834	12
13	Various		1984	13,999		20			16,014	13
14	Various		1985	189,803		20			180,084	14
15	Various		1986	36,791		20			42,181	15
16	Various		1987	26,840		20			23,840	16
17	Various		1988	41,929		20			41,929	17
18	Various		1989	614,857		20			501,126	18
19	Various		1990	84,534		20			121,841	19
20	Various		1991	30,632		20			4,223	20
21	Various		1992	18,213		20			18,213	21
22	Various		1993	10,084		20			10,084	22
23	Various		1994	31,384		20	425	425	9,342	23
24	Various		1995	4,965		20			4,965	24
25	Various		1996	5,267		20			5,267	25
26	Various		1997	28,305		20	599	599	11,377	26
27	Various		1998	2,109,189		20	105,459	105,459	1,898,269	27
28	Various		1999	180,129		20	9,005	9,005	153,101	28
29	Various		2000	4,050,990		20	200,835	200,835	3,213,355	29
30	Various		2001	104,552		20			104,552	30
31	Various		2002	60,740		20			60,740	31
32	Various		2003	88,626		20	1,098	1,098	14,270	32
33	Various		2004	79,166		20	3,958	3,958	47,187	33
34	Various		2005	17,390		20	870	870	9,567	34
35	Various		2006	55,760		20	2,788	2,788	27,880	35
36	Various		2007	134,749		20	6,737	6,737	56,965	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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2008	\$ 163,760	\$	20	\$ 9,166	\$ 9,166	\$ 65,336	37
38	Various	2009	90,584		20	7,831	7,831	41,257	38
39	Door Opener Replacement	2010	4,703		20	235	235	1,410	39
40	Brandel Remodeling - Architecture And Window Treatments	2010	12,741		20	637	637	3,185	40
41	Re-Key Brandel Care Center	2010	15,107		20	735	735	3,695	41
42	Plumbing Work	2010	20,600		20	1,030	1,030	4,855	42
43	Brandel Therapy Wing Remodel - Walls, Floors, Ceilings, Window	2010	353,493		20	17,675	17,675	71,730	43
44	Walking Garden	2010	14,950		20	748	748	3,740	44
45	Brandel Wing Remodel - Architech Fees	2012	600		20	15	15	45	45
46	BCC 100 Wing HVAC	2012	3,698		20	92	92	276	46
47	New Doors Brandel	2012	26,990		20	675	675	2,025	47
48	Brandel Insulation	2012	3,600		20	90	90	270	48
49	BCC/AL Connecting Roof	2012	18,558		20	464	464	1,392	49
50	BCC Roof Drains	2012	19,064		20	476	476	1,428	50
51	BCC HVAC Rooftop	2012	74		20	2	2	6	51
52	BCC 100 WING Door	2012	3,236		20	81	81	243	52
53	HC Fire Sprinkler	2012	8,439		20	211	211	633	53
54	Doors- Brandel	2012	22,515		20	563	563	1,689	54
55	Memory Support Unit Countertop	2012	6,340		20	158	158	474	55
56	Brandel Wing Remodel - Architech Fees	2012	12,619		20	316	316	948	56
57	Brandel Wing Remodel-FD-Flooring, Lighting, Doors, Paint, Ceiling, Reconstruct Dining Area	2012	222,126		20	5,553	5,553	16,659	57
58									58
59	Brandel Wing Remodel-SG-Fire Alarms/Fire Sprinkler Upgrades	2012	5,601		20	140	140	420	59
60	Flooring for 100 Wing Resident Rms, 300 Dining Rm, 400 Wing Dining Rm, 2 Admin Offices.	2013	241,777		20	12,089	12,089	24,178	60
61									61
62	Orchard Dining Room Remodel	2013	34,502			1,725	1,725	3,450	62
63	Orchard Court Memory Care - Kitchen Upgrades Electrical, Plumbing, Carpentry & Flooring	2014	23,197		20	580	580	580	63
64									64
65	BHR Toilet Renovation 2 Patient Rooms Replacement and Raising Memory Care Unit	2014	5,438		20	136	136	133	65
66									66
67	Front Entrance Automatic Door Opener System BHR	2014	2,512		20	63	63	61	67
68	Financial Statement Depreciation			511,141			(511,141)		68
69									69
70	TOTAL (lines 4 thru 69)		\$ 10,932,619	\$ 511,141		\$ 393,624	\$ (117,517)	\$ 10,094,728	70

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,466,216	\$	\$ 146,622	\$ 146,622	10	\$	71
72	Current Year Purchases	13,956		1,396	1,396	10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,480,172	\$	\$ 148,017	\$ 148,017		\$	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		Bus	2010	\$ 5,869	\$	\$ 1,173	\$ 1,173	5	\$ 5,869	76
77										77
78										78
79										79
80	TOTALS			\$ 5,869	\$	\$ 1,173	\$ 1,173		\$ 5,869	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)	\$ 12,489,381	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 511,141	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 542,814	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 31,673	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 10,100,597	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: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

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

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 12,800 Description: See Attached

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

* 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.

Covenant Health Care Center - Northbrook
0033779
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<u>Description</u>	<u>Amount</u>
Copier	6,588.00
Therapy Equipment Lease	6,212.00
	<u>12,800.00</u>

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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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		Contract	Total
		1 Drop-outs	2 Completed		
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	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39-03	hrs	\$		\$	288,272	\$			\$	288,272	1	
2	Licensed Speech and Language Development Therapist	39-03	hrs				81,603					81,603	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39-03	hrs				380,065					380,065	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy		# of prescripts						212,076			212,076	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify): <u>See Attached</u>						49,155		196,171			245,326	12	
13	Other (specify):												13	
14	TOTAL			\$		\$	799,095	\$	408,247		\$	1,207,342	14	

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

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<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
13A Therapy-NURSING & MED SUPP (NMSB) BILL	91.00
13B Resident Ancillary Services-NURSING & MED SUPP (NMSB) BILL	117,869.00
13C Nursing-NURSING & MED SUPP (NMSN) NON-	45,888.00
13D Wellness-NURSING & MED SUPP (NMSB) BILL	23,980.00
13E Nursing-NURSING & MED SUPP (NMSN) NON-	8,343.00
13F	
13G	
13H	
13I	
13J	
	<u>196,171.00</u>

<u>Special Services - Outside (Column 5 - Other)</u>	
13K Laboratory And X-Ray (Lax) Expense	45,039.00
13L Oxygen	3,133.00
13M Consultant Services	488.00
13N Equipment Rentals	495.00
13O	
13P	
13Q	
13R	
13S	
13T	
	<u>49,155.00</u>

<u>Special Services - Outside (Column 5 - Other)</u>	
13U	
13V	
13W	
13X	
13Y	
13Z	
	<u> </u>

—
—

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk

0033779

Report Period Beginning: 02/01/2014

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	2	
		Operating	After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits	133		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>36,773</u>)	1,673,320		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	723		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached</u>	59,275		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,733,451	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	70,272		13
14	Buildings, at Historical Cost	9,845,576		14
15	Leasehold Improvements, at Historical Cost	42,526		15
16	Equipment, at Historical Cost	1,227,530		16
17	Accumulated Depreciation (book methods)	(7,852,268)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	30,889		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(15,696)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached</u>	17,612,727		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 20,961,556	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 22,695,007	\$	25

		1	2	
		Operating	After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 163,987	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	335,020		30
31	Accrued Taxes Payable (excluding real estate taxes)	43,002		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	10,573		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached</u>	52,488		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 605,070	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,344,232		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)	\$ 1,344,232	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,949,302	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 20,745,705	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 22,695,007	\$	48

*(See instructions.)

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Other Current Assets:		<u>Amount</u>
09A	Other-ACC INT DEBT SERVICE RESERVES	1,200
09B	Other-BOND SINKING FUND	47,299
09C	Other-BOND INTEREST FUND	10,776
09D		
09E		
09F		
09G		
		<u>59,275</u>

Other Non-Current Assets:		<u>Amount</u>
23A	Other-BENEVOLENT CARE FUND	1,088,549
23B	Other-CAPITAL RESERVE FUND	5,205,560
23C	Other-PROPERTY REPLACEMENT FUND	993,035
23D	Other-DEBT SERVICE RESERVE FUND	154,689
23E	Other-ORIGINAL ISSUE DISCOUNT (OID)	9,311
23F	Other-ACCUM AMORTORTIZATION - OID	(1,130)
23G	Other-ORIGINAL ISSUE PREMIUM (OIP)	(92,457)
23H	Other-ACCUMULATED ACCRETION - OIP	38,868
23I	Other-Admin - Zone 91	7,063,918
23J	Other-Admin - Zone 91	3,152,384
		<u>#####</u>

Other Current Liabilities:		<u>Amount</u>
36A	Other-RESIDENT TRUST FUNDS	(133)
36B	Other-OTHER CURRENT LIABILITIES	(9,785)
36C	Other-DEFERRED MAINTENANCE	(23,844)
36D	Other-DESIGN CONTRIBUTIONS-GENERAL	(18,226)
36E	Other-DESIGN CONTRIBUTIONS-GENERAL	(500)
36F		
36G		
		<u>(52,488)</u>

	<u>Amount</u>
43A	
43B	
43C	
43D	
43E	
43F	
43G	

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 19,717,358	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 19,717,358	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,028,347	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,028,347	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)	\$ 20,745,705	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

		1	2
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,097,931	1
2	Discounts and Allowances for all Levels	(1,239,207)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,858,724	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,433,221	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,433,221	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	39,370	13
14	Non-Patient Meals	5,718	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	504	16
17	Sale of Drugs	288,173	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,636	19
20	Radiology and X-Ray		20
21	Other Medical Services	272,141	21
22	Laundry	40,360	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 678,902	23
D. Non-Operating Revenue			
24	Contributions	21,911	24
25	Interest and Other Investment Income****	476,388	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 498,299	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached</u>	62,170	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 62,170	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,531,316	30

		1	2
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,502,886	31
32	Health Care	3,389,164	32
33	General Administration	2,573,938	33
B. Capital Expense			
34	Ownership	615,567	34
C. Ancillary Expense			
35	Special Cost Centers	1,228,019	35
36	Provider Participation Fee	193,395	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,502,969	40
41	Income before Income Taxes (line 30 minus line 40)**	1,028,347	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,028,347	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 1,339,288	44
45	Private Pay - Net Inpatient Revenue	4,619,209	45
46	Medicare - Net Inpatient Revenue	1,628,800	46
47	Other-(specify) <u>Insurance/ Managed Care</u>	271,427	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,858,724	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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	<u>Description</u>	<u>Amount</u>
28A	Other-TRANSPORTATION REVENUE	(5,922.00)
28B	Other-TRANSFER TEMP RESTR FOR OPER	(6,456.00)
28C	Other-OTHER SERVICES	(24.00)
28D	Other-OTHER OPERATING INCOME	(3,141.00)
28E	Other-INVESTMENT PROPERTY REVENUE	(1,422.00)
28F	Other-INTERCAMPUS REVENUE	(39,795.00)
28G	Other-TRANSPORTATION REVENUE	(362.00)
28H	Other-TRANSFER TEMP RESTR FOR OPER	(1,602.00)
28I	Other-OTHER SERVICES	(10.00)
28J	Other-OTHER OPERATING INCOME	(2,671.00)
28K	Other-INVESTMENT PROPERTY REVENUE	(609.00)
28L	Other-INC ON OTHER	(156.00)
28M		
28N		
28O		
28P		
28Q		
28R		
28S		
28T		<u>(62,170)</u>

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk

0033779

Report Period Beginning:

02/01/2014

Ending:

01/31/2015

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	1,872	2,080	\$ 98,301	\$ 47.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,425	36,677	1,203,339	32.81	3
4	Licensed Practical Nurses	5,924	6,433	172,193	26.77	4
5	CNAs & Orderlies	80,955	88,998	1,333,969	14.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,872	2,080	49,193	23.65	9
10	Activity Assistants	8,601	9,297	153,511	16.51	10
11	Social Service Workers	6,017	7,178	144,242	20.10	11
12	Dietician					12
13	Food Service Supervisor	653	706	15,808	22.39	13
14	Head Cook	6,006	6,673	106,401	15.95	14
15	Cook Helpers/Assistants	15,538	16,480	177,349	10.76	15
16	Dishwashers					16
17	Maintenance Workers	4,099	4,529	107,491	23.73	17
18	Housekeepers	8,534	9,700	128,599	13.26	18
19	Laundry	2,071	2,177	35,250	16.19	19
20	Administrator	1,436	1,638	100,600	61.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,524	10,406	277,235	26.64	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	1,700	1,877	52,565	28.00	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Barber and Beaut</u>	913	1,006	18,914	18.80	33
34	TOTAL (lines 1 - 33)	189,140	207,935	\$ 4,174,960 *	\$ 20.08	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly \$ 44,238	01-03	35
36	Medical Director	Monthly 53,280	09-03	36
37	Medical Records Consultant			37
38	Nurse Consultant			38
39	Pharmacist Consultant	Monthly 6,505	10-03	39
40	Physical Therapy Consultant			40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant	44 1,319	10-03	42
43	Speech Therapy Consultant			43
44	Activity Consultant	4 280	11-03	44
45	Social Service Consultant	Monthly 7,111	12-03	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	48 \$ 112,733		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	283 7,197	10-03	52
53	TOTAL (lines 50 - 52)	283 \$ 7,197		53

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Account Number	Account Description	Amount
4140-4701-0	Nursing-TRAVEL AND AUTO	85.00
4141-4701-0	Activities-TRAVEL AND AUTO	90.00
4142-4701-0	Chaplains-TRAVEL AND AUTO	511.00
4143-4701-0	Social Services-TRAVEL AND AUTO	4,018.00
4170-4701-0	Maintenance-TRAVEL AND AUTO	111.00
4180-4701-0	Administrative and General-TRAVEL AND AUTO	6,719.00
4642-4701-0	Chaplains-TRAVEL AND AUTO	308.00
4643-4701-0	Social Services-TRAVEL AND AUTO	446.00
4670-4701-0	Maintenance-TRAVEL AND AUTO	62.00
4680-4701-0	Administrative and General-TRAVEL AND AUTO	471.00
		<u>12,821.00</u>

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AcctDesc.	Unit	Acct	Date/Description	DR	CR
CONSULTANT SERVICES	4711	Nursing	12 01/18/15 AP I 1910225 57943Assured Hea		340
CONFERENCES AND SEMINARS	4641	Nursing	06 07/31/14 AP I 1910143 56530HOLIDAY INN		605.46
TRAINING	4651	Nursing	02 03/31/14 AP I 1910110 52636Focus On Ag		105
TRAINING	4651	Nursing	02 03/31/14 AP I 1910110 52636Focus On Ag		105
TRAINING	4651	Nursing	02 03/31/14 AP I 1910140 52636Focus On Ag		105
TRAINING	4651	Nursing	03 04/30/14 AP I 1910120 21470SUPERIOR AI		420
TRAINING	4651	Nursing	03 04/30/14 AP I 1910120 52636Focus On Ag		105
TRAINING	4651	Nursing	03 04/30/14 AP I 1910172 52636Focus On Ag		105
CONFERENCES AND SEMINARS	4641	Activities	04 05/31/14 GL N 18 Bergstrom, K; EB TH		75
CONFERENCES AND SEMINARS	4641	Activities	04 05/31/14 GL N 18 Bergstrom, K; PAYPAL		49
TRAINING	4651	Activities	03 04/30/14 AP I 1910172 999001202Northern Il		40
CONFERENCES AND SEMINARS	4641	Chaplains	11 12/04/14 AP I 1910036 38566RICHARD BER		315
TRAINING	4651	Maintenance	01 02/28/14 GL N 18 Fennema, D; Amazon;		7.24
TRAINING	4651	Maintenance	08 09/30/14 AP I 1910200 42550BANK OF AMI		8.68
CONFERENCES AND SEMINARS	4641	Administrative and General	02 03/12/14 AP I 1910083 40145Grand Genev		844.73
CONFERENCES AND SEMINARS	4641	Administrative and General	02 03/31/14 AP I 1910039 46603Northern Il		466.56
CONFERENCES AND SEMINARS	4641	Administrative and General	06 07/31/14 GL N 18 Fennema, D; LEADIN;		95.4
CONFERENCES AND SEMINARS	4641	Administrative and General	06 07/31/14 GL N 18 Fennema, D; AMERIC;		29.36
CONFERENCES AND SEMINARS	4641	Administrative and General	07 08/26/14 AP I 1910168 39435Jonathan Ka		795
TRAINING	4651	Administrative and General	11 12/31/14 GL N 16 Fennema, D; PES-NA;		45
TRAINING	4651	Nursing	02 03/31/14 AP I 1910110 52636Focus On Ag		45
TRAINING	4651	Nursing	02 03/31/14 AP I 1910110 52636Focus On Ag		45
TRAINING	4651	Nursing	02 03/31/14 AP I 1910140 52636Focus On Ag		45
TRAINING	4651	Nursing	03 04/30/14 AP I 1910120 52636Focus On Ag		45
TRAINING	4651	Nursing	03 04/30/14 AP I 1910172 52636Focus On Ag		45
TRAINING	4651	Maintenance	01 02/28/14 GL N 18 Fennema, D; Amazon;		3.62
TRAINING	4651	Maintenance	08 09/30/14 AP I 1910200 42550BANK OF AMI		3.72
TRAINING	4651	Administrative and General	11 12/31/14 GL N 16 Fennema, D; PES-NA;		22.5
CONFERENCES AND SEMINARS	4641	Administrative and General	02 03/12/14 AP I 1910083 40145Grand Genev		422.35
CONFERENCES AND SEMINARS		Administrative and General	02 03/31/14 AP I 1910039 46603Northern Il		233.28
CONFERENCES AND SEMINARS		Administrative and General	06 07/31/14 GL N 18 Fennema, D; LEADIN;		47.7
CONFERENCES AND SEMINARS		Administrative and General	06 07/31/14 GL N 18 Fennema, D; AMERIC;		14.69

5,634

7,838

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	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

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 and Leading Age
- (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? _____
- (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. \$ 55,046 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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 193,395
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? N/A
- (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. \$ 5,718
- (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? N/A
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? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Plante & Moran
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.