FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0033779

Facility Name: Covenant Hlth Cr Ctr Nrthbrk

Address: 2155 Pfingsten Road (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 01/20/1972

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501c(3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,758	16,743	6,814	30,315	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,758	16,743	6,814	30,315	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.43%

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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 01/20/1972

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

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 102 and days of care provided

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

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

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	290,695	7,699	45,067	343,461		343,461		343,461			1
2	Food Purchase		333,775		333,775		333,775	(4,816)	328,959			2
3	Housekeeping	128,349	24,686	350	153,385		153,385		153,385			3
4	Laundry	19,978	8,966	94,609	123,553		123,553		123,553			4
5	Heat and Other Utilities			133,602	133,602		133,602		133,602			5
6	Maintenance	74,560	32,325	191,772	298,657		298,657	(472)	298,185			6
7	Other (specify):*											7
8	TOTAL General Services	513,582	407,451	465,400	1,386,433		1,386,433	(5,288)	1,381,145			8
	B. Health Care and Programs											
9	Medical Director			120,640	120,640		120,640		120,640			9
10	Nursing and Medical Records	2,884,000	58,736	27,818	2,970,554		2,970,554		2,970,554			10
10a	Therapy											10a
11	Activities	207,703	1,312	22,010	231,025		231,025		231,025			11
12	Social Services	118,565	366	30,386	149,317		149,317	(7,574)	141,743			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,210,268	60,414	200,854	3,471,536		3,471,536	(7,574)	3,463,962			16
	C. General Administration											
17	Administrative	122,766		506,844	629,610		629,610	(506,844)	122,766			17
18	Directors Fees											18
19	Professional Services			45,922	45,922		45,922	(120,558)	(74,636)			19
20	Dues, Fees, Subscriptions & Promotions			117,082	117,082		117,082	(75,098)	41,984			20
21	Clerical & General Office Expenses	299,837		403,967	703,804		703,804	353,229	1,057,033			21
22	Employee Benefits & Payroll Taxes			1,014,614	1,014,614		1,014,614		1,014,614			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,396	8,396		8,396		8,396			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			85,130	85,130		85,130		85,130			26
27	Other (specify):*											27
28	TOTAL General Administration	422,603		2,181,955	2,604,558		2,604,558	(349,271)	2,255,287			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,146,453	467,865	2,848,209	7,462,527		7,462,527	(362,133)	7,100,394			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk #0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			623,698	623,698		623,698		623,698			30
31	Amortization of Pre-Op. & Org.			2,998	2,998		2,998		2,998			31
32	Interest			51,350	51,350		51,350	(51,350)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,341	14,341		14,341		14,341			35
36	Other (specify):*											36
37	**TOTAL Ownership**			692,387	692,387		692,387	(51,350)	641,037			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		427,167	773,203	1,200,370		1,200,370		1,200,370			39
40	Barber and Beauty Shops	23,391		1,837	25,228		25,228	(25,228)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			174,324	174,324		174,324		174,324			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	23,391	427,167	949,364	1,399,922		1,399,922	(25,228)	1,374,694			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,169,844	895,032	4,489,960	9,554,836		9,554,836	(438,711)	9,116,125			45

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,816)	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		30		9
10	Interest and Other Investment Income	(51,350)	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	(93,594)	21		24
25	Fund Raising, Advertising and Promotional	(75,098)	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	(125,612)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (350,470)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (350,470)		37

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

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

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

Covenant Hlth Cr Ctr Nrthbrk

ID# 0033779

Report Period Beginning: 02/01/2015

Ending: 01/31/2016

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber & Beauty	$ (25,228)	40	1
2	Guest Apartment Revnue	(472)	06	2
3	Transportation Revenue	(7,574)	12	3
4	Other Services Revenue	(38)	21	4
5	Other Operating Income	(41,100)	21	5
6	Intercampus Revenue	(49,160)	21	6
7	Investment Property Revenue	(2,040)	21	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**	(125,612)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk **#** 0033779 **Report Period Beginning:** 02/01/2015 **Ending:** 01/31/2016

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,816)	0	0	0	0	0	0	0	0	0	0	(4,816)	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	(472)	0	0	0	0	0	0	0	0	0	0	(472)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,288)	0	0	0	0	0	0	0	0	0	0	(5,288)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(7,574)	0	0	0	0	0	0	0	0	0	0	(7,574)	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(7,574)	0	0	0	0	0	0	0	0	0	0	(7,574)	16
	C. General Administration													
17	Administrative	0	(506,844)	0	0	0	0	0	0	0	0	0	(506,844)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(120,558)	0	0	0	0	0	0	0	0	0	(120,558)	19
20	Fees, Subscriptions & Promotions	(75,098)	0	0	0	0	0	0	0	0	0	0	(75,098)	20
21	Clerical & General Office Expenses	(185,932)	539,161	0	0	0	0	0	0	0	0	0	353,229	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**	(261,030)	(88,241)	0	0	0	0	0	0	0	0	0	(349,271)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(273,892)	(88,241)	0	0	0	0	0	0	0	0	0	(362,133)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk **#** 0033779 **Report Period Beginning:** 02/01/2015 **Ending:** 01/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(51,350)	0	0	0	0	0	0	0	0	0	0	(51,350)	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**	(51,350)	0	0	0	0	0	0	0	0	0	0	(51,350)	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	(25,228)	0	0	0	0	0	0	0	0	0	0	(25,228)	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**	(25,228)	0	0	0	0	0	0	0	0	0	0	(25,228)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(350,470)	(88,241)	0	0	0	0	0	0	0	0	0	(438,711)	45

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

VII. RELATED PARTIES

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

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

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

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

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Office Expense - CRC Alloc.	$	Covenant Retirement Communities		$	$ 628,037	1
2	V	21	Other Operating Exp.	14,956	Covenant Retirement Communities			(14,956)	2
3	V	19	Consultant Services	87,635	Covenant Retirement Communities			(87,635)	3
4	V	21	IS Fees - Software	73,920	Covenant Retirement Communities			(73,920)	4
5	V	19	Legal Services	4,000	Covenant Retirement Communities			(4,000)	5
6	V	17	Management Services Fees	506,844	Covenant Retirement Communities			(506,844)	6
7	V	19	Payroll Services	28,923	Covenant Retirement Communities			(28,923)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 716,278			$	$ * (88,241)	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: 02/01/2015 Ending: 01/31/2016

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	Jon P. Aagaard, M.D.	BOD	Covenant Village Care Center - Florida	Plantation, FL				1
2	Pamela Christensen	BOD	Brandel Care Center	Northbrook, IL				2
3	Kara Davis	BOD	Windsor Park Manor	Carol Stream, IL				3
4	Rev. Harvey Drake§	BOD	Covenant Village Care Center - Turlock	Turlock, CA				4
5	Mark Eastburg	BOD	Mount Miguel Covenant Village	Spring Valley, CA				5
6	James Elving§	BOD	Samarkand Skilled Nursing	Santa Barbara, CA				6
7	Marc Espinosa§	BOD	Colonial Acres Care Center	Golden Valley, MN				7
8	Carol A. Findling	BOD	Covenant Vilage of the Great Lakes	Grand Rapids, MI				8
9	Lorene G. Flewellen§	BOD	Covenant Village of Colorado	Westminster, CO				9
10	Rhoda Friesen§	BOD	Pilgrim Manor	Cromwell, CT				10
11	Thomas F. Heywood	BOD	Covenant Shores	Mercer Island, WA				11
12	Donald Hodgkinson	BOD	Brandel Manor	Turlock, CA				12
13	Kathy Holmgren	BOD						13
14	Jody Holt	BOD						14
15	Scott Macdonald	BOD						15
16	Marlene E. Stante	BOD						16
17	Anne Vining	BOD						17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

VII. RELATED PARTIES (continued)

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

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

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: Covenant Retirement Communities
Street Address: 5700 Old Orchard Road
City / State / Zip Code: Skokie, IL 60077
Phone Number: (773) 878-2294
Fax Number: (773) 878-2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Office Expense - CRC Allocation	Total Expense			$	$		$ 628,037	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					$	$		$ 628,037	25

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	2012 C Col Tax Ex Bonds		X	Capital Improvements		2012	$	$ 665,718			$ 37,102	1
2	2012 A 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						$	$ 1,204,917			$ 62,512	9
	B. Non-Facility Related*											
10	Accretion of OIP		X								(12,350)	10
11	Financing Assesment		X								1,188	11
12	Interest Adjustment										(51,350)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (62,512)	14
15	TOTALS (line 9+line14)						$	$ 1,204,917			$	15

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

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

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011		8
	2012		9
	2013		10
	2014		11
	2015		12

N/A - Facility does not pay real estate taxes due to Not-For-Profit status.

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

NOTES:

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

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

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

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (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? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 18,224
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 2,998
4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1973	$ 70,271	1
2					2
3	TOTALS			$ 70,271	3

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	102		1974	1974	$ 1,467,409	$	40	$	$	$ 1,467,409	4
5			1975	1975	2,250		40			2,250	5
6			1976	1976	1,916		40			1,916	6
7			1977	1977	2,769		40			2,769	7
8			1978	1978	7,643		40			7,643	8
	Improvement Type**										
9	Various			1979	18,220		40	455	455	17,081	9
10	Various			1980	20,844		20			20,844	10
11	Various			1981	38,116		40	953	953	33,828	11
12	Various			1982	1,709,834		40	42,752	42,752	1,474,697	12
13	Various			1984	13,999		40	344	344	11,246	13
14	Various			1985	189,803		40	4,517	4,517	141,687	14
15	Various			1986	36,791		20			36,791	15
16	Various			1987	26,840		40	596	596	17,583	16
17	Various			1988	41,929		40	1,066	1,066	29,670	17
18	Various			1989	614,857		40	12,528	12,528	344,524	18
19	Various			1990	84,534		40	3,046	3,046	80,720	19
20	Various			1991	30,632		20			30,632	20
21	Various			1992	18,213		40	858	858	18,213	21
22	Various			1993	10,084		20			10,084	22
23	Various			1994	31,384		20			31,384	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			28,305	26
27	Various			1998	2,109,189		20			2,109,189	27
28	Various			1999	180,129		20	9,006	9,006	157,613	28
29	Various			2000	4,050,990		20	203,703	203,703	3,198,454	29
30	Various			2001	104,552		20	10,217	10,217	104,552	30
31	Various			2002	60,740		20	6,203	6,203	60,740	31
32	Various			2003	88,626		20	4,587	4,587	58,432	32
33	Various			2004	79,166		20	1,217	1,217	14,379	33
34	Various			2005	17,390		20	2,773	2,773	17,390	34
35	Various			2006	55,760		20	3,091	3,091	29,410	35
36	Various			2007	134,749		20	2,414	2,414	20,545	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2008	$ 163,760	$	20	$ 6,893	$ 6,893	$ 54,047	37
38	Various	2009	90,584		20	2,953	2,953	19,197	38
39	Various	2010	421,594		20	5,629	5,629	28,983	39
40	Brandel Wing Remodel - Architecht Fees	2012	600		20	30	30	105	40
41	BCC 100 Wing HVAC	2012	3,698		20	185	185	647	41
42	New Doors Brandel	2012	26,990		20	1,350	1,350	4,723	42
43	Brandel Insulation	2012	3,600		20	180	180	630	43
44	BCC/AL Connecting Roof	2012	18,558		20	928	928	3,248	44
45	BCC Roof Drains	2012	19,064		20	953	953	3,336	45
46	BCC HVAC Rooftop	2012	74		20	4	4	13	46
47	BCC 100 WING Door	2012	3,236		20	162	162	566	47
48	HC Fire Sprinkler	2012	8,439		20	422	422	1,477	48
49	Doors- Brandel	2012	22,515		20	1,126	1,126	3,940	49
50	Memory Support Unit Countertop	2012	6,340		20	317	317	1,110	50
51	Brandel Wing Remodel - Architecht Fees	2012	12,619		20	631	631	2,208	51
52	Brandel Wing Remodel-FD-Flooring, Lighting, Doors, Paint,								52
53	Ceiling Reconstruct Dining Area	2012	222,126		20	11,106	11,106	38,872	53
54	Brandel Wing Remodel-SG-Fire Alarms/Fire Sprinkler Upgrades	2012	5,601		20	280	280	980	54
55	Flooring for 100 Wing Resident Rooms, 300 Dining Room,								55
56	400 Wing Dining Room, 2 Administrative Offices.	2013	241,777		20	25,297	25,297	62,683	56
57	Orchard Dining Room Remodel	2013	34,502		20	1,803	1,803	4,468	57
58	Orchard Court Memory Care - Kitchen Upgrades Electrical,								58
59	Plumbing, Carpentry & Flooring	2014	23,197		20	1,160	1,160	1,740	59
60	BHR Toilet Renovation 2 Patient Rooms Memory Care Unit	2014	5,438		20	272	272	407	60
61	Front Entrance Automatic Door Opener System BHR	2014	2,512		20	126	126	188	61
62	Kitchen Remodel- Fire Supression Counters - Fixed Equipment								62
63	Fryer/Ranges/Exhuast Ventilator Kitchen Line	2015	97,678		20	4,884	4,884	4,884	63
64	Brandel - Kitchen - Floor Grease Trap replacement	2015	6,495		20	325	325	325	64
65	Room 411-413 wall plumbing carrige support / New Toilets	2015	4,018		20	201	201	201	65
66	Fire Doors - 200 Wing	2015	6,748		20	169	169	169	66
67	Therapy Gym, 200 and 300 Wing Kitchens/Dining Rooms								67
68	300 Wing Lounge/200 Wing Activities Office/Storage/ Exam RM	2016	1,620,790		20	81,040	81,040	81,040	68
69	Financial Statement Depreciation			623,698			(623,698)		69
70	TOTAL (lines 4 thru 69)		$ 14,360,448	$ 623,698		$ 458,751	$ (164,947)	$ 9,910,399	70

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 14,360,448	$ 623,698		$ 458,751	$ (164,947)	$ 9,910,399	1
2	Awning Pergola Orchard Entrance	2015	5,868		20	147	147	147	2
3	BHR Pastoral Office - Carpeting/ Carpentry/Paint	2015	321		20	83	83	83	3
4	Fire Barriers - Brandel - At each Fire Door/Wall facility Wide	2015	5,794		20	290	290	290	4
5	Nurse Call System Hard Wired	2016	480,941		10	24,047	24,047	24,047	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	TOTAL (lines 1 thru 33)		$ 14,853,372	$ 623,698		$ 483,318	$ (140,380)	$ 9,934,966	34

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,357,367	$	$ 134,790	$ 134,790		$ 723,744	71
72	Current Year Purchases	29,237		5,003	5,003		5,003	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,386,604	$	$ 139,793	$ 139,793		$ 728,747	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	$	$ 587	$ 587	5	$ 5,869	76
77										77
78										78
79										79
80	TOTALS			$ 5,869	$	$ 587	$ 587		$ 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)	$ 16,316,116	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 623,698	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 623,698	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 0	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 10,669,582	85	

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2017	$
13.	/2018	$
14.	/2019	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,341 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.

Covenant Health Care Center - Northbrook
0033779
Page 14 Supplemental
02/01/2015-1/31/2016

Description	Amount
Copier	7,373.00
Therapy Equipment Lease	6,968.00
Total	14,341.00

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-03	hrs	$ 298,747		$	$		$ 298,747	1
2	Licensed Speech and Language Development Therapist	39-03	hrs	58,091					58,091	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-03	hrs	366,102					366,102	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			241,629			241,629	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Attached			50,263		185,538			235,801	13
14	TOTAL			$ 773,203		$ 427,167	$		$ 1,200,370	14

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

Covenant Health Care Center - Northbrook
0033779
Page 16 Supplemental
02/01/15-01/31/16

	Special Services - Supplies (Column 6 - Other)	Amount
13A	Therapy-NURSING & MED SUPP (NMSB) BILL	400.00
13B	Therapy-NURSING & MED SUPP (NMSN) NON-	195.00
13C	Resident Ancillary Services-NURSING & MED SUPP (NMSB) BILL	84,163.00
13D	Nursing-NURSING & MED SUPP (NMSN) NON-	71,803.00
13E	Wellness-NURSING & MED SUPP (NMSB) BILL	21,939.00
13F	Nursing-NURSING & MED SUPP (NMSN) NON-	6,196.00
13G	Resient Ancillary Services - Equioment Repairs	842.00
13H		
13I		
13J		
	Total	#########

	Special Services - Outside (Column 5 - Other)	
13K	Laboratory And X-Ray (Lax) Expense	47,172.00
13L	Consultant Services	300.00
13M	Equipment Rentals	2,791.00
13N		
13O		
13P		
13Q		
13R		
13S		
13T		
	Total	50,263.00

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk **#** 0033779 **Report Period Beginning:** 02/01/2015 **Ending:** 01/31/2016

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	8,127		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (88,623))	1,706,505		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,626		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	27,345		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,743,603	$	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	12,077,229		14
15	Leasehold Improvements, at Historical Cost	42,526		15
16	Equipment, at Historical Cost	1,386,604		16
17	Accumulated Depreciation (book methods)	(8,471,618)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	30,889		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(18,224)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	16,864,349		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 21,982,027	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 23,725,630	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 137,270	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	344,822		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,937		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	9,645		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	145,085		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 681,759	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,204,917		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)**	$ 1,204,917	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,886,676	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 21,838,954	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 23,725,630	$	48

***(See instructions.)**

Covenant Health Care Center - Northbrook
0033779
Page 17 Supplemental
02/01/15-01/31/16

Other Current Assets:	**Amount**
Other-ACC INT DEBT SERVICE RESERVES	1,106
Other-BOND SINKING FUND	16,594
Other-BOND INTEREST FUND	9,645
	27,345

Other Non-Current Assets:	**Amount**
Other-BENEVOLENT CARE FUND	1,088,549
Other-CAPITAL RESERVE FUND	5,272,120
Other-PROPERTY REPLACEMENT FUND	264,327
Other-DEBT SERVICE RESERVE FUND	127,607
Other-ORIGINAL ISSUE DISCOUNT (OID)	9,311
Other-ACCUM AMORTORTIZATION - OID	(1,600)
Other-ORIGINAL ISSUE PREMIUM (OIP)	(92,457)
Other-ACCUMULATED ACCRETION - OIP	51,218
Other-Admin - Zone 91	6,382,361
Other-Admin - Zone 91	3,762,913
	16,864,349

Other Current Liabilities:	**Amount**
Other-RESIDENT TRUST FUNDS	(8,127)
Other-OTHER CURRENT LIABILITIES	(107,232)
Other-DEFERRED MAINTENANCE	-
Other-DESIGN CONTRIBUTIONS-GENERAL	(29,226)
Other-DESIGN CONTRIBUTIONS-GENERAL	(500)
	(145,085)

Other Non-Current Liabilities:	**Amount**

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 20,745,705	1
2	Restatements (describe):		2
3	**Irrevocable Trust Beginning Balance Restatement**	7,422	3
4	**Rounding**	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 20,753,129	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,085,825	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)**	$ 1,085,825	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)**	$ 21,838,954	24 *

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

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,127,026	1
2	Discounts and Allowances for all Levels	(1,272,773)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,854,253	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,478,755	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,478,755	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	45,384	13
14	Non-Patient Meals	4,816	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	472	16
17	Sale of Drugs	288,290	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	35,494	19
20	Radiology and X-Ray		20
21	Other Medical Services	307,648	21
22	Laundry	33,220	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 715,324	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	492,037	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 492,037	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	100,292	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 100,292	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,640,661	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,386,433	31
32	Health Care	3,471,536	32
33	General Administration	2,604,558	33
	B. Capital Expense		
34	Ownership	692,387	34
	C. Ancillary Expense		
35	Special Cost Centers	1,225,598	35
36	Provider Participation Fee	174,324	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,554,836	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,085,825	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,085,825	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,055,298	44
45	Private Pay - Net Inpatient Revenue	5,090,620	45
46	Medicare - Net Inpatient Revenue	1,608,213	46
47	Other-(specify) Ins./MCO	100,122	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,854,253	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.**

Covenant Health Care Center - Northbrook
0033779
Page 19 Supplemental
02/01/14-01/31/15

Description	Amount
Other-TRANSPORTATION REVENUE	(7,112.00)
Dining-Internal Cost Allocation	(380.00)
Other-OTHER SERVICES	(26.00)
Other-OTHER OPERATING INCOME	(40,969.00)
Other-INVESTMENT PROPERTY REVENUE	(1,428.00)
Other-INTERCAMPUS REVENUE	(49,160.00)
Other-TRANSPORTATION REVENUE	(462.00)
Other-OTHER SERVICES	(12.00)
Other-OTHER OPERATING INCOME	(131.00)
Other-INVESTMENT PROPERTY REVENUE	(612.00)
	(100,292)

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,944	2,080	$ 97,647	$ 46.95	1
2	Assistant Director of Nursing					2
3	Registered Nurses	33,831	36,932	1,232,324	33.37	3
4	Licensed Practical Nurses	4,875	5,407	141,342	26.14	4
5	CNAs & Orderlies	80,040	87,649	1,355,252	15.46	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,080	48,833	23.48	9
10	Activity Assistants	8,675	9,376	158,870	16.94	10
11	Social Service Workers	5,029	5,625	118,565	21.08	11
12	Dietician					12
13	Food Service Supervisor	671	760	17,497	23.02	13
14	Head Cook	4,824	5,510	88,995	16.15	14
15	Cook Helpers/Assistants	16,408	17,292	184,203	10.65	15
16	Dishwashers					16
17	Maintenance Workers	2,868	3,181		0.00	17
18	Housekeepers	8,736	9,719	128,349	13.21	18
19	Laundry	1,543	1,786	19,978	11.19	19
20	Administrator	1,665	1,872	122,766	65.58	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,858	10,885	299,837	27.55	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	1,671	1,913	57,435	30.02	31
32	Other Health Care(specify)					32
33	Other(specify) Barber & Beauty	1,115	1,230	23,391	19.02	33
34	TOTAL (lines 1 - 33)	185,657	203,297	$ 4,095,284 *	$ 20.14	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 44,358	01-03	35
36	Medical Director	Monthly	120,640	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	14,833	10-03	38
39	Pharmacist Consultant	Monthly	5,866	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	26,170	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 211,867		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	217	5,414	10-03	52
53	TOTAL (lines 50 - 52)	217	$ 5,414		53

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jonathan Kaspar	Administrator	0%	$ 122,766
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 122,766

B. Administrative - Other

Description	Amount
Covenant Retirement Communities	$ 506,844
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 506,844

C. Professional Services

Vendor/Payee	Type	Amount
CRC	Legal	$ 4,000
Holleran Consultging	Resident Satisfaction	5,891
FGMK, LLC	Consulting	6,200
Jeremy Brune	Accounting	2,200
Plante Moran	Accounting	10,117
Mix Solutions	Mock Survey	2,200
Marcum, LLP	Mock Survey	840
Polaris Group	Mock Survey	9,500
Elias Leraning	Mock Survey	4,974
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 45,922

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 128,311
Unemployment Compensation Insurance	2,419
FICA Taxes	298,166
Employee Health Insurance	435,243
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
403(B) Matching Contribution	64,728
Pension Plan Expense	69,641
Group Life/Disability	9,021
Employee Recognition	4,408
Employee Benefits - Other	2,677
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,014,614

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	423
Health Care Worker Background Check (Indicate # of checks performed 198)	1,988
Patient Background Checks	
Licenses & Permits	24,061
Dues & Subscriptions	11,532
Marketing/Advertising	55,832
Promotion/PR-Commissions	19,266
Less: Public Relations Expense	(19,266)
Non-allowable advertising	(55,832)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 41,984

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,698
Seminar Expense	698
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,396

**See instructions.

FACILITY NAME: Covenant Village of Northbrook
AUTO AND TRAVEL
SUPPLEMENTAL SCHEDULE
02/01/2015-01/31/2016

DATE	EMPLOYEE NAME	JOB DESCRIPTION	DESTINATION	PURPOSE OF TRIP	FOOD	AIRFARE	Mileage	PARKING	OTHER	TOTAL
02/28/15	Connie Branstrom	Referral Liason	Evanston Hospital	Sales				17.5		17.50
03/31/15	Connie Branstrom	Referral Liason	Evanston Hospital	Sales				17.5		17.50
09/30/15	Connie Branstrom	Referral Liason	Evanston Hospital	Sales				21		21.00
10/12/15	Audrey Frieland	Director of Nursing	Smith & Hudson	Deposition			38	18		56.00
04/30/205	Kandace Bergstrom	Healthcare Activities Supervisor	Village of Northbrook						39	39.00
04/30/205			Summit 2015						5250	5,250.00
08/31/15		Payroll Distribution 08/13/15							252.81	252.81
09/30/15			Summit Reversal						-2428	(2,428.00)
01/31/16	Jonathan Kaspar	Administrator		FEDEX mailing					167.9	167.90
09/30/15		Payroll Distribution 09/24/15							78.31	78.31
01/31/16	Connie Branstrom	Referral Liason	Various	Sales			4226.98			4,226.98
										7,699.00

FACILITY NAME: Covenant Village of Northbrook
SEMINAR EXPENSE
02/01/2015-01/31/2016

DATE	PAYEE	TOPIC	ATTENDEE	JOB DESCRIPTION	CITY/STATE	FEE
02/28/15	Northern Illinois University	Leading Age - IL Annual Meeting & Exhibition	Doug Fennema	Associate Executive Director	Dekalb, IL	269.85
02/28/15	Northern Illinois University	Leading Age - IL Annual Meeting & Exhibition	S Prescod	Administrative Assistant	Dekalb, IL	270.00
02/28/15	Richard Bergstrom	Midwinter Conference Chaplains	Richard Bergstrom	Chaplain	IL	157.83
						697.68

Facility Name & ID Number Covenant Hlth Cr Ctr Nrthbrk # 0033779 Report Period Beginning: 02/01/2015 Ending: 01/31/2016

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? **Ye**
If YES, give association name and amount. **LSN/Leading Age**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **58,301** Line **10-2**

(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 fo
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 Departmen
during this cost report period. $ **174,324**
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 tc
the Department, in addition to the daily rate, been properly classifiec
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 fo
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. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **4,816**

(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 fo
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
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