FOR BHF USE

LL1

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

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 CC Northbrk

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: 01/20/72

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Jeremy M. Brune, CPA **Telephone Number:** (779) 875 - 3979
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 02/01/16 to 01/31/17 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) Jeremy M. Brune, CPA, CEO
(Firm Name & Address) Jeremy Brune & Associates, LLC, 2508 Riverwalk Drive Plainfield, Illinois 60586
(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	6,669	16,022	7,357	30,048	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	6,669	16,022	7,357	30,048	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.71%

D. How many bed reserve days during this year were paid by the Department?
0 (Do not include bed reserve 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 01/20/72

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 6,313

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

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

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

Tax Year: 01/31/17 Fiscal Year: 01/31/17

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	319,627	59,824	53,255	432,706		432,706		432,706			1
2	Food Purchase		303,232		303,232		303,232	(5,442)	297,790			2
3	Housekeeping	139,494	27,488	5,671	172,653		172,653		172,653			3
4	Laundry	19,418	10,331	113,534	143,283		143,283		143,283			4
5	Heat and Other Utilities			126,918	126,918		126,918		126,918			5
6	Maintenance	76,278	34,805	143,414	254,497		254,497	(797)	253,700			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	554,817	435,680	442,792	1,433,289		1,433,289	(6,239)	1,427,050			8
	B. Health Care and Programs											
9	Medical Director			68,600	68,600		68,600		68,600			9
10	Nursing and Medical Records	3,016,645	163,181	238,686	3,418,512		3,418,512		3,418,512			10
10a	Therapy											10a
11	Activities	181,634	2,794	9,446	193,874		193,874		193,874			11
12	Social Services	197,015	335	20,269	217,619		217,619		217,619			12
13	CNA Training											13
14	Program Transportation	12,256			12,256		12,256	(5,845)	6,411			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	3,407,550	166,310	337,001	3,910,861		3,910,861	(5,845)	3,905,016			16
	C. General Administration											
17	Administrative	104,830			104,830		104,830		104,830			17
18	Directors Fees											18
19	Professional Services			774,279	774,279		774,279	(87,953)	686,326			19
20	Dues, Fees, Subscriptions & Promotions			15,320	15,320		15,320		15,320			20
21	Clerical & General Office Expenses	278,077	17,184	353,743	649,004		649,004	(306,063)	342,941			21
22	Employee Benefits & Payroll Taxes			1,032,109	1,032,109		1,032,109		1,032,109			22
23	Inservice Training & Education			2,419	2,419		2,419		2,419			23
24	Travel and Seminar			8,895	8,895		8,895	(690)	8,205			24
25	Other Admin. Staff Transportation			4,646	4,646		4,646	(4,646)				25
26	Insurance-Prop.Liab.Malpractice			75,081	75,081		75,081	(5,932)	69,149			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	382,907	17,184	2,266,492	2,666,583		2,666,583	(405,284)	2,261,299			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,345,274	619,174	3,046,285	8,010,733		8,010,733	(417,368)	7,593,365			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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 CC Northbrk #0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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			784,297	784,297		784,297		784,297			30
31	Amortization of Pre-Op. & Org.			2,384	2,384		2,384	(2,384)				31
32	Interest			58,503	58,503		58,503	(58,503)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,180	12,180		12,180		12,180			35
36	Other (specify):* See Supplemental											36
37	**TOTAL Ownership**			857,364	857,364		857,364	(60,887)	796,477			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		378,620	771,724	1,150,344		1,150,344		1,150,344			39
40	Barber and Beauty Shops	35,345	830		36,175		36,175	(36,175)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			210,395	210,395		210,395		210,395			42
43	Other (specify):* See Supplemental			84,152	84,152		84,152	(84,152)				43
44	**TOTAL Special Cost Centers**	35,345	379,450	1,066,271	1,481,066		1,481,066	(120,327)	1,360,739			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,380,619	998,624	4,969,920	10,349,163		10,349,163	(598,582)	9,750,581			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Covenant Hlth CC Northbrk
Medicaid Cost Report
02/01/16 - 01/31/17

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Line 36 - Other Capital Costs				
				-
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	-	-
Line 43 - Other Special Cost Centers				
Marketing / Fundraising			84,152	84,152
				-
				-
				-
				-
				-
				-
Sub-Total	-	-	84,152	84,152

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	(5,442)	02		4
5	Telephone, TV & Radio in Resident Rooms	(9,387)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(58,503)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17,100)	21		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	(277,421)	21		24
25	Fund Raising, Advertising and Promotional	(84,152)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(58,624)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (510,629)		$	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)	(87,953)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (87,953)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (598,582)		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

SEE ACCOUNTANTS' PREPARATION REPORT

Covenant Hlth CC Northbrk

ID# 0033779

Report Period Beginning: 02/01/16

Ending: 01/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Barber and Beauty Shop Revenue	$ (36,175)	40	1
2	Guest Apartment Revenue	(708)	06	2
3	Transportation Revenue	(5,845)	14	3
4	Maintenance Revenue	(89)	06	4
5	Other Service Revenue	(2,155)	21	5
6	Directors and Officers Insurance	(5,932)	26	6
7	Amortized Debts Costs	(2,384)	31	7
8	Non-Allowable Seminar	(690)	24	8
9	Non-Allowable Travel	(4,646)	25	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**	(58,624)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 **Report Period Beginning:** 02/01/16 **Ending:** 01/31/17

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	(5,442)	0	0	0	0	0	0	0	0	0	0	(5,442)	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	(797)	0	0	0	0	0	0	0	0	0	0	(797)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,239)	0	0	0	0	0	0	0	0	0	0	(6,239)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(5,845)	0	0	0	0	0	0	0	0	0	0	(5,845)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(5,845)	0	0	0	0	0	0	0	0	0	0	(5,845)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(87,953)	0	0	0	0	0	0	0	0	0	(87,953)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(306,063)	0	0	0	0	0	0	0	0	0	0	(306,063)	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	(690)	0	0	0	0	0	0	0	0	0	0	(690)	24
25	Other Admin. Staff Transportation	(4,646)	0	0	0	0	0	0	0	0	0	0	(4,646)	25
26	Insurance-Prop.Liab.Malpractice	(5,932)	0	0	0	0	0	0	0	0	0	0	(5,932)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(317,331)	(87,953)	0	0	0	0	0	0	0	0	0	(405,284)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(329,415)	(87,953)	0	0	0	0	0	0	0	0	0	(417,368)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 **Report Period Beginning:** 02/01/16 **Ending:** 01/31/17

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	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(2,384)	0	0	0	0	0	0	0	0	0	0	(2,384)	31
32	Interest	(58,503)	0	0	0	0	0	0	0	0	0	0	(58,503)	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**	(60,887)	0	0	0	0	0	0	0	0	0	0	(60,887)	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	(36,175)	0	0	0	0	0	0	0	0	0	0	(36,175)	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):*	(84,152)	0	0	0	0	0	0	0	0	0	0	(84,152)	43
44	**TOTAL Special Cost Centers**	(120,327)	0	0	0	0	0	0	0	0	0	0	(120,327)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(510,629)	(87,953)	0	0	0	0	0	0	0	0	0	(598,582)	45

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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, Inc.	100.00%	See Page 6 - Supplemental				

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Home Office	$ 737,425	Covenant Retirement Communities, Inc.	100.00%	$ 649,472	$ (87,953)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 737,425			$ 649,472	$ * (87,953)	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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								1
2	Non-Profit Board of Directors							2
3								3
4	Jon Aagaard, MD		Brandel Manor	Turlock , CA	Covenant Ministries			4
5	Pamela Christensen		Covenant Health Care Ctr - Northbrook	Northbrook, IL	of Benevolence	Chicago, IL	Corporate Office	5
6	Kara Davis		Colonial Acres Healthcare	Golden Valley, MN	Covenant Retirement			6
7	Mark Eastburg		Covenant Shores HC	Mercer Island, WA	Communities	Skokie, IL	Home Office	7
8	Jim Elving		Covenant Village Care Center	Plantation, FL	Brandel Manor	Turlock, CA	Asst. Living	8
9	Marc Espinosa		Covenant Village of Turlock	Turlock, CA	Covenant Village			9
10	Rhoda Friesen		Covenant Village of Colorado	Westminister, CO	of Northbrook	Northbrook, IL	Asst. & Ind. Living	10
11	Thomas Heywood		Covenant Health Care Ctr - Batavia	Batavia, IL	Covenant Villae			11
12	Donald Hodgkinson		Mount Miguel Covenant Village	Spring Valley, CA	of Golden Valley	Golden Valley, MN	Asst. & Ind. Living	12
13	Kathy Holmgren		The Samarkand	Santa Barbara, CA	Covenant Shores	Mercer Island, WA	Asst. & Ind. Living	13
14	Jody Holt		Windsor Park Manor	Carol Stream, IL	Covenant Village			14
15	Scott Macdonald		Covenant Village of Great Lakes	Grand Rapids, MI	of Florida	Plantation, FL	Asst. & Ind. Living	15
16	Matthew Manlove				Covenant Village			16
17	Dale Rinard				of Turlock	Turlock, CA	Asst. & Ind. Living	17
18	Marlene Stante				Covenant Village			18
19	Anne Vinding				of Colorado	Westminister, CO	Asst. & Ind. Living	19
20					The Holmstad	Batavia, IL	Asst. & Ind. Living	20
21					Mount Miguel			21
22					Covenant Village	Spring Valley, CA	Asst. & Ind. Living	22
23					The Samarkand	Santa Barbara, CA	Asst. & Ind. Living	23
24					Windsor Park Manor	Carol Stream, IL	Asst. & Ind. Living	24
25					Covenant Village			25
26					of Great Lakes	Grand Rapids, MI	Asst. & Ind. Living	26
27					Covenant Home			27
28					of Chicago	Chicago, IL	Supportive Living	28
29					Est. of Windsor Park	Carol Stream, IL	Ind. Living	29
30					Cov. Care at Home		Home Health	30

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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									$		1
2	N/A										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**

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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, Inc.
Street Address: 5700 Old Orchard Road
City / State / Zip Code: Skokie, Illinois 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	19	Home Office	Operating Expenses	318,937,000	31	$ 20,891,163	$ 6,611,595	9,915,225	$ 649,472	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					$ 20,891,163	$ 6,611,595		$ 649,472	25

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	2012A Colorado Rev Bonds		X	Capital Improvements		2012	$	$ 543,434	2034	4.5 - 5.0%	$ 25,410	1
2	2012C Colorado Rev Bonds		X	Capital Improvements		2012		587,768	2023	2.0 - 5.0%	31,905	2
3												3
4												4
5												5
	Working Capital											
6	Financing Assessment		X								1,188	6
7												7
8												8
9	TOTAL Facility Related						$	$ 1,131,202			$ 58,503	9
	B. Non-Facility Related*											
10	Interest Income		X								(58,503)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (58,503)	14
15	TOTALS (line 9+line14)						$	$ 1,131,202			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

** 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 CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 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 2017 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:		
	2012	8
	2013	9
	2014	10
	2015	11
	2016	12

N/A - Covenant Health Care Center - Northbrook is a non-profit corporation that is not subject to real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

SEE ACCOUNTANTS' PREPARATION REPORT

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Hlth CC Northbrk COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033779

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 X 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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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 CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 77,894 B. General Construction Type: Exterior Brick Masonry Frame Steel 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. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1973	$ 70,272	1
2					2
3	TOTALS			$ 70,272	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	$ 1,467,406	$		$	$	$	4
5			1975	1975	2,250						5
6			1976	1976	1,916						6
7			1977	1977	2,769						7
8			1978	1978	7,643						8
	Improvement Type**										
9	Various			1979	18,220						9
10	Various			1980	20,844						10
11	Various			1981	38,116						11
12	Various			1982	17,734						12
13	Various			1984	13,999						13
14	Various			1985	189,803						14
15	Various			1986	36,791						15
16	Various			1987	26,840						16
17	Various			1988	41,930						17
18	Various			1989	614,857						18
19	Various			1990	84,534						19
20	Various			1991	30,632						20
21	Various			1992	18,213						21
22	Various			1993	10,084						22
23	Various			1994	31,384						23
24	Various			1995	4,965						24
25	Various			1996	5,267						25
26	Various			1997	28,305						26
27	Various			1998	2,109,189						27
28	Various			1999	180,129						28
29	Various			2000	4,050,990						29
30	Various			2001	104,552						30
31	Various			2002	60,740						31
32	Various			2003	88,626						32
33	Various			2004	77,434						33
34	Various			2005	17,390						34
35	Various			2006	9,227						35
36	Various			2007	134,749						36

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

See Page 12A, Line 70 for total

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	$		$	$	$	37
38	Various	2009	90,584						38
39	Various	2010	421,594						39
40	Various	2011	34,694						40
41	Various	2012	353,460						41
42	Various	2013	276,279						42
43	Electrical, Plumbing, Carpentry, and Flooring - Orchard Court	2014	23,197						43
44	Toilet Renovations - 2 Patient Rooms	2014	5,438						44
45	Automatic Door Opening System - Front Entrance	2014	2,512						45
46	Fire Supression Counters, Exhaust, and Fixed Equipment - Kitchen	2015	97,678						46
47	Floor Grease Trap Replacement - Kitchen	2015	6,495						47
48	New Toilets and Wall Plumbing Carriage - Rooms 411 - 413	2015	4,018						48
49	Fire Doors - 200 Wing	2015	6,748						49
50	Pergola - Outside Awning	2015	5,868						50
51	Carpeting, Carpenty, and Paint - Pastoral Office	2015	321						51
52	Fire Barriers - Fire Doors and Walls (Facility Wide)	2015	5,794						52
53	Flooring, Design, Fire Patch Drywalls, Blinds, Curtains, Painting	2016	1,620,790						53
54	Nurse Call System - Hard Wired	2016	480,941						54
55	Ceiling Tiles, Lighting, Flooring, Rails, Window Treatments,	2016							55
56	Paint, Cabinets, Toilets, Grab Bars - Resident Rooms / Baths	2016	404,743						56
57	Sewer Line Replacement - 400 Wing	2016	8,015						57
58	Trans Switch to Generator System	2016	4,427						58
59	Ceiling Tiles, Lighting, Flooring, Rails, Window Treatments,	2016							59
60	Paint, Cabinets, Toilets, Grab Bars - Resident Rooms / Baths	2016	313,680						60
61	Gazebo	2017	7,101						61
62	Fire Barrier - Upgraded	2017	3,698						62
63	Replaced Fire Panel Connected to Sprinkler System	2017	43,473						63
64	Canopy	2017	4,985						64
65	Sound System - Dining Room and Chapel	2017	17,750						65
66									66
67									67
68	Depreciation: Covenant Health Care Center - Northbrook			784,297		784,297		9,198,485	68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,955,571	$ 784,297		$ 784,297	$	$ 9,198,485	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	$ 1,386,604	$	$	$		$	71
72	Current Year Purchases	165,975						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,552,579	$	$	$		$	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	Facility	Bus	2010	$ 5,869	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 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)	$ 15,584,291	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 784,297	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 784,297	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 9,198,485	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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	See Suppl				0			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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 12,180 Description: See Supplemental Schedule
(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.

SEE ACCOUNTANTS' PREPARATION REPORT

Covenant Hlth CC Northbrk
Medicaid Cost Report
02/01/16 - 01/31/17

Page 14 Supplemental Schedule

Building Rental

Desciption	Amount	Total
N/A		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	-	-

Equipment Rental

Copier	5,580	5,580
Therapy Equipment	6,600	6,600
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	12,180	12,180

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 315,743	$		$ 315,743	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			63,917			63,917	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			355,976			355,976	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				248,566		248,566	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					130,054		130,054	12
13	Other (specify): See Supplemental	39 - 03				36,088			36,088	13
14	TOTAL			$		$ 771,724	$ 378,620		$ 1,150,344	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.

SEE ACCOUNTANTS' PREPARATION REPORT

Covenant Hlth CC Northbrk
Medicaid Cost Report
02/01/16 - 01/31/17

Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		129,646		129,646
Therapy Supplies		408		408
Laboratory and Radiology			36,088	36,088
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	130,054	36,088	166,142

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 01/31/17 (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	2,145		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 276,737)	959,733		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,822		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 968,700	$	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	12,063,657		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,411,363		16
17	Accumulated Depreciation (book methods)	(9,198,485)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	101,374		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(114,665)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	17,983,707		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 23,317,223	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 24,285,923	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 427,367	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	2,145		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	364,600		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,046		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	9,093		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 819,251	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	1,122,109		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,122,109	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,941,360	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 22,344,563	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 24,285,923	$	48

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

Covenant Hlth CC Northbrk
Medicaid Cost Report
02/01/16 - 01/31/17

Page 17 Supplemental Schedule

Description	Operating	Building	Total
Line 9 - Other Current Assets			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 23 - Long Term Assets			
Construction in Progress	108,375		108,375
Intercompany Receivable	11,139,865		11,139,865
Endowment Reserve Fund(s)	1,088,549		1,088,549
Debt Service Reserve Fund(s)	159,941		159,941
Capital Reserve Fund(s)	5,486,976		5,486,976
Sub-Total	17,983,707	-	17,983,707
Line 36 - Other Current Liability			
			-
			-
			-
			-
			-
Sub-Total	-	-	-
Line 43 - Long term Liabilities			
			-
			-
			-
			-
			-
Sub-Total	-	-	-

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 21,838,955	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 21,838,955	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	505,608	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)**	$ 505,608	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)**	$ 22,344,563	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,168,816	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,168,816	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	133,354	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 133,354	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	44,700	13
14	Non-Patient Meals	5,442	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	708	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	78	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 50,928	23
	D. Non-Operating Revenue		
24	Contributions	9,574	24
25	Interest and Other Investment Income***	483,987	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 493,561	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	8,112	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 8,112	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,854,771	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,433,289	31
32	Health Care	3,910,861	32
33	General Administration	2,666,583	33
	B. Capital Expense		
34	Ownership	857,364	34
	C. Ancillary Expense		
35	Special Cost Centers	1,270,671	35
36	Provider Participation Fee	210,395	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,349,163	40
41	**Income before Income Taxes (line 30 minus line 40)****	505,608	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 505,608	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,016,901	44
45	Private Pay - Net Inpatient Revenue	5,363,805	45
46	Medicare - Net Inpatient Revenue	3,312,806	46
47	Other-(specify) Insurance - Net Inpatient Revenue	451,160	47
48	Other-(specify) Hospice - Net Inpatient Revenue	24,144	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 10,168,816	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final 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.

SEE ACCOUNTANTS' PREPARATION REPORT

Covenant Hlth CC Northbrk
Medicaid Cost Report
02/01/16 - 01/31/17

Page 19 Supplemental Schedule

Description	Amount	Total
Transportation Revenue	5,845	5,845
Maintenance Revenue	89	89
Miscellaneous Revenue	2,178	2,178
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	8,112	8,112

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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	1,864	2,080	$ 114,511	$ 55.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	30,078	33,109	1,152,775	34.82	3
4	Licensed Practical Nurses	6,946	7,542	209,663	27.80	4
5	CNAs & Orderlies	81,681	89,185	1,437,439	16.12	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,784	2,080	52,381	25.18	9
10	Activity Assistants	8,764	9,390	129,253	13.76	10
11	Social Service Workers	5,636	6,073	164,540	27.09	11
12	Dietician					12
13	Food Service Supervisor	1,213	1,504	35,319	23.48	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,260	22,498	284,308	12.64	15
16	Dishwashers					16
17	Maintenance Workers	2,748	3,043	76,278	25.07	17
18	Housekeepers	9,045	10,058	139,494	13.87	18
19	Laundry	1,544	1,677	19,418	11.58	19
20	Administrator	1,557	1,738	104,830	60.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,515	9,782	278,077	28.43	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	1,657	1,899	59,194	31.17	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	5,249	5,632	123,139	21.86	33
34	TOTAL (lines 1 - 33)	189,541	207,290	$ 4,380,619 *	$ 21.13	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		68,600	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		40,500	10 - 03	38
39	Pharmacist Consultant		7,086	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		7,537	12 - 03	45
46	Other(specify)				46
47	See Supplemental Schedule		26,040	Various	47
48					48
49	TOTAL (lines 35 - 48)		$ 149,763		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 60,073	10 - 03	50
51	Licensed Practical Nurses		62,230	10 - 03	51
52	Certified Nurse Assistants/Aides		57,513	10 - 03	52
53	TOTAL (lines 50 - 52)		$ 179,816		53

Covenant Hlth CC Northbrk
Medicaid Cost Report
02/01/16 - 01/31/17

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Ward Clerk	10 - 01	2,109	2,198	43,063	19.59		
Chaplains	12 - 01	769	915	32,475	35.49		
Transportation	14 - 01	603	652	12,256	18.80		
Barber and Beauty	40 - 01	1,768	1,867	35,345	18.93		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		5,249	5,632	123,139	21.86		
Contracted Services							
Dietary Management / Staffing	01 - 03						16,114
Chaplains	12 - 03						9,926
Total						-	26,040

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Neil Warnygora	Exec. Dir.	0	$ 17,393
Seth Awes	Assc.. Exec. Dir	0	6,027
Jonathan Kasper	Administrator	0	81,410
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 104,830

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Cov. Ret. Communities	Home Office	$ 737,425
Plante & Moran, PLLC	Audit	11,882
WIPFLI, LLP	Accounting / Consulting	6,549
Marcum, LLP	Consulting	2,225
FGMK, LLC	Accounting	4,100
Jeremy Brune & Assoc., LLC	Accounting	2,200
Holleran Consulting	Consulting	7,105
Mix Solutions	Consulting	2,200
Other	Other	593
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 774,279

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 103,022
Unemployment Compensation Insurance	946
FICA Taxes	316,699
Employee Health Insurance	438,310
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Benefits	152,299
Group Life and Disability Insurance	9,234
Employee Recognition	7,383
Employee Physicals	1,626
Other Employee Benefits	2,590
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,032,109

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,489
Health Care Worker Background Check	1,091
(Indicate # of checks performed)	
Patient Background Checks	
Dues and Subscriptions	9,584
Licenses and Permits	156
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,320

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,895
Non-Allowable	(690)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,205

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

Covenant Hlth CC Northbrk
Medicaid Cost Report
02/01/16 - 01/31/17

Page 21 Supplemental Schedule - Seminar

Vendor	Session Title	Seminar Date	Location	Attendee	Amount	Non-Allowable	Allowable
Karen Hinz	Triennial Conference		Kansas City, MO	K. Hinz	690	690	-
Willow Creek Association	Leadership Summit		Palatine, IL	BHR Directors	760		760
Northern Illinois Univerisy	Leading Age Summit		Schaumburg, IL	BHR Directors	1,532		1,532
Karen Bergstrom					158		158
Relias Learning	Online Program				5,755		5,755
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
							-
Total					8,895	690	8,205

Facility Name & ID Number Covenant Hlth CC Northbrk # 0033779 Report Period Beginning: 02/01/16 Ending: 01/31/17

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. **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? **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? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **57,113** Line **10 - 02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **210,395**
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.

SEE ACCOUNTANTS' PREPARATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **5,442**

(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? **Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Plante & Moran, PLLC**

(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? **N/A**
See page 39 of the instructions for details.
Attach invoices and a summary of services for all architect and appraisal fees