

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0025577</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Michaelsen Health Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>10/01/19</u> to <u>09/30/20</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>831 N Batavia Avenue</u> <u>Batavia</u> <u>60510</u>																									
Number City Zip Code																									
County: <u>Kane</u>																									
Telephone Number: <u>(630) 879 - 4000</u> Fax # <u>(630) 879 - 8483</u>																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Jean Justie</u></td></tr><tr><td>(Title) <u>Chief Financial Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>Chief Executive Officer</u></td></tr><tr><td>(Firm Name & Address) <u>Jeremy Brune & Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u></td></tr><tr><td>(Telephone) <u>(779) 875 - 3979</u> Fax # <u>(866) 216 - 5355</u></td></tr><tr><td>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</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Jean Justie</u>	(Title) <u>Chief Financial Officer</u>	(Signed) _____	Paid Preparer	(Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>Chief Executive Officer</u>	(Firm Name & Address) <u>Jeremy Brune & Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u>	(Telephone) <u>(779) 875 - 3979</u> Fax # <u>(866) 216 - 5355</u>	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												
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Date of Initial License for Current Owners: <u>05/09/80</u>																									
Type of Ownership:																									
<table><tr><td>☒ VOLUNTARY, NON-PROFIT</td><td>☐ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☒ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☐ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL	☒ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code <u>501(c)(3)</u>	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☐ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☒ VOLUNTARY, NON-PROFIT	☐ PROPRIETARY	☐ GOVERNMENTAL																							
☒ Charitable Corp.	☐ Individual	☐ State																							
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	☐ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Jeremy M. Brune, CPA</u> Telephone Number: <u>(779) 875 - 3979</u>																									
Email Address: _____																									

SEE ACCOUNTANTS' PREPARATION REPORT

#	0025577	Report Period Beginning:	10/01/19	Ending:	09/30/20
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D. How many bed reserve days during this year were paid by the Department?

0 (Do not include bed reserve days in Section B.)

N/A

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 05/06/80

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

YES ☒ Date 05/06/80 NO ☐

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

YES ☒ NO ☐ If YES, enter number
of beds certified 99 and days of care provided

Medicare Intermediary **National Government Services, Inc.**

IV. ACCOUNTING BASIS

ACCRUAL	☒	MODIFIED		
CASH*	☐	CASH*	☐	

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

Tax Year: 09/30/20 **Fiscal Year:** 09/30/20

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

SEE ACCOUNTANTS' PREPARATION REPORT

B. Census-For the entire report period.

	1 Level of Care	2	3	4	5	
		Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	5,725	15,555	6,695	27,975	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,725	15,555	6,695	27,975	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.21 %

Facility Name & ID Number Michaelsen Health Center # 0025577 Report Period Beginning: 10/01/19 Ending: 09/30/20

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	343,984	52,432	117,286	513,702		513,702		513,702			1
2	Food Purchase		244,169		244,169		244,169	(20,536)	223,633			2
3	Housekeeping	267,706	80,451	4,336	352,493		352,493		352,493			3
4	Laundry		17,777	59,520	77,296		77,296		77,296			4
5	Heat and Other Utilities			200,695	200,695		200,695	(15,983)	184,712			5
6	Maintenance	104,091	14,662	123,977	242,731		242,731	4,393	247,124			6
7	Other (specify):* See Supplemental	21,814			21,814		21,814	10	21,824			7
8	TOTAL General Services	737,595	409,491	505,814	1,652,900		1,652,900	(32,116)	1,620,784			8
	B. Health Care and Programs											
9	Medical Director			33,500	33,500		33,500		33,500			9
10	Nursing and Medical Records	3,508,301	185,663	215,636	3,909,601		3,909,601		3,909,601			10
10a	Therapy											10a
11	Activities	123,421	2,479	5,383	131,282		131,282		131,282			11
12	Social Services	204,103		1,996	206,098		206,098		206,098			12
13	CNA Training											13
14	Program Transportation	22,881		7,621	30,503		30,503	(15,184)	15,319			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	3,858,706	188,142	264,136	4,310,984		4,310,984	(15,184)	4,295,800			16
	C. General Administration											
17	Administrative	154,285			154,285		154,285	50,285	204,570			17
18	Directors Fees											18
19	Professional Services			926,640	926,640		926,640	(822,848)	103,792			19
20	Dues, Fees, Subscriptions & Promotions			71,022	71,022		71,022	10,336	81,358			20
21	Clerical & General Office Expenses	259,315	9,391	409,672	678,378		678,378	87,506	765,884			21
22	Employee Benefits & Payroll Taxes			1,063,418	1,063,418		1,063,418		1,063,418			22
23	Inservice Training & Education			382	382		382	212	594			23
24	Travel and Seminar			1,592	1,592		1,592	14,458	16,050			24
25	Other Admin. Staff Transportation			1,022	1,022		1,022	13,309	14,331			25
26	Insurance-Prop.Liab.Malpractice			133,010	133,010		133,010	3,349	136,359			26
27	Other (specify):* See Supplemental							62,075	62,075			27
28	TOTAL General Administration	413,600	9,391	2,606,759	3,029,750		3,029,750	(581,318)	2,448,432			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,009,901	607,024	3,376,709	8,993,635		8,993,635	(628,618)	8,365,017			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.

Page 3 Supplemental Schedule

Description		Salaries		Supplies		Other		Total
Line 7 - Other General Services								
Security		21,814						21,814
CLCS Allocation								-
Employee Benefits						10		10
								-
								-
								-
								-
Sub-Total		<u>21,814</u>		<u>-</u>		<u>10</u>		<u>21,824</u>
Line 15 - Other Health Care Services								
								-
								-
								-
								-
								-
								-
								-
Sub-Total		<u>-</u>		<u>-</u>		<u>-</u>		<u>-</u>
Line 27 - Other General Administration								
CLCS Allocation								-
Employee Benefits						62,075		62,075
								-
								-
								-
								-
								-
Sub-Total		<u>-</u>		<u>-</u>		<u>62,075</u>		<u>62,075</u>

Michaelsen Health Center
 Medicaid Cost Report
 10/01/19 - 09/30/20

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

Employee	Travel Purpose	Travel Destination	Travel Date	Expenses			Total
				Travel	Accomodations	Meals	
Sally Pierce	Mileage Reimbursement	Various	10/31/19	53	-	-	53
James Perkis	Mileage Reimbursement	Various	12/31/19	11	-	-	11
James Perkis	Mileage Reimbursement	Various	12/31/19	11	-	-	11
James Perkis	Mileage Reimbursement	Various	12/31/19	100	-	-	100
James Perkis	Mileage Reimbursement	Various	12/31/19	133	-	-	133
Amanda Gosner	Hotel		12/31/19	-	714	-	714
							-
CLCS (Allocation)	Various	Various	Various	13,309			13,309
							-
							-
							-
							-
							-
							-
							-
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							-
							-
Total				13,617	714	-	14,331

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			596,922	596,922		596,922	38,684	635,606			30
31	Amortization of Pre-Op. & Org.			11,905	11,905		11,905	(11,905)	0			31
32	Interest			559,424	559,424		559,424	(314,063)	245,361			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			14,994	14,994		14,994		14,994			35
36	Other (specify):* See Supplemental							6,244	6,244			36
37	TOTAL Ownership			1,183,245	1,183,245		1,183,245	(281,040)	902,205			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		378,306	792,931	1,171,236		1,171,236		1,171,236			39
40	Barber and Beauty Shops			5,977	5,977		5,977		5,977			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			199,131	199,131		199,131		199,131			42
43	Other (specify):* See Supplemental	120,261	1,393	14,013	135,667		135,667		135,667			43
44	TOTAL Special Cost Centers	120,261	379,698	1,012,053	1,512,012		1,512,012		1,512,012			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,130,162	986,723	5,572,006	11,688,891		11,688,891	(909,658)	10,779,233			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

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
CLCS Allocation								-
Property Costs						6,244		6,244
								-
								-
								-
								-
Sub-Total		-		-		6,244		6,244
Line 43 - Other Special Cost Centers								
Marketing & Fund Raising		120,261		1,393		13,313		134,967
Donations						700		700
								-
								-
								-
								-
Sub-Total		120,261		1,393		14,013		135,667

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	(20,536)	02		4
5	Telephone, TV & Radio in Resident Rooms	(17,952)	05		5
6	Rented Facility Space	(830)	06		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	(314,063)	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	(341,029)	21		24
25	Fund Raising, Advertising and Promotional				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	(29,377)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (723,787)		\$	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)	(185,871)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (185,871)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (909,658)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Maintenance Revenue	\$ (315)	06	1
2	Transportation Revenue	(15,184)	14	2
3	Other Revenue	(1,103)	21	3
4	Collections	(870)	19	4
5	Amortization	(11,905)	31	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
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31				31
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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	(29,377)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Michaelson Health Center# 0025577

Report Period Beginning:

10/01/19

Ending:

09/30/20

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	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(20,536)	0	0	0	0	0	0	0	0	0	0	(20,536)	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	(17,952)	0	1,969	0	0	0	0	0	0	0	0	(15,983)	5
6	Maintenance	(1,145)	92	5,446	0	0	0	0	0	0	0	0	4,393	6
7	Other (specify):*	0	10	0	0	0	0	0	0	0	0	0	10	7
8	TOTAL General Services	(39,633)	102	7,415	0	0	0	0	0	0	0	0	(32,116)	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	(15,184)	0	0	0	0	0	0	0	0	0	0	(15,184)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(15,184)	0	0	0	0	0	0	0	0	0	0	(15,184)	16
	C. General Administration													
17	Administrative	0	50,285	0	0	0	0	0	0	0	0	0	50,285	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(870)	0	(821,978)	0	0	0	0	0	0	0	0	(822,848)	19
20	Fees, Subscriptions & Promotions	0	0	10,336	0	0	0	0	0	0	0	0	10,336	20
21	Clerical & General Office Expenses	(342,132)	293,866	135,772	0	0	0	0	0	0	0	0	87,506	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	212	0	0	0	0	0	0	0	0	212	23
24	Travel and Seminar	0	0	14,458	0	0	0	0	0	0	0	0	14,458	24
25	Other Admin. Staff Transportation	0	0	13,309	0	0	0	0	0	0	0	0	13,309	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,349	0	0	0	0	0	0	0	0	3,349	26
27	Other (specify):*	0	62,075	0	0	0	0	0	0	0	0	0	62,075	27
28	TOTAL General Administration	(343,002)	406,226	(644,542)	0	0	0	0	0	0	0	0	(581,318)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(397,819)	406,328	(637,127)	0	0	0	0	0	0	0	0	(628,618)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Michaelson Health Center # 0025577 Report Period Beginning: 10/01/19 Ending: 09/30/20

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	38,684	0	0	0	0	0	0	0	0	38,684	30
31	Amortization of Pre-Op. & Org.	(11,905)	0	0	0	0	0	0	0	0	0	0	(11,905)	31
32	Interest	(314,063)	0	0	0	0	0	0	0	0	0	0	(314,063)	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	6,244	0	0	0	0	0	0	0	0	6,244	36
37	TOTAL Ownership	(325,968)	0	44,928	0	0	0	0	0	0	0	0	(281,040)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(723,787)	406,328	(592,199)	0	0	0	0	0	0	0	0	(909,658)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Covenant Living Communities & Services	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.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance - Salary	\$	Covenant Living Communities & Services	100.00%	\$ 92	\$	92
2	V	7	Employee Benefits		Covenant Living Communities & Services	100.00%	10		10
3	V	17	Administration - Salary		Covenant Living Communities & Services	100.00%	50,285		50,285
4	V	21	Office & Clerical - Salary		Covenant Living Communities & Services	100.00%	293,866		293,866
5	V	27	Employee Benefits		Covenant Living Communities & Services	100.00%	62,075		62,075
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			\$			\$ 406,328	\$ *	406,328

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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	\$	Covenant Living Communities & Services	100.00%	\$ 1,969	\$ 1,969	15
16	V	6	Maintenance - Other		Covenant Living Communities & Services	100.00%	5,446	5,446	16
17	V	19	Professional Services	917,987	Covenant Living Communities & Services	100.00%	96,009	(821,978)	17
18	V	20	Dues, Fees & Subscriptions		Covenant Living Communities & Services	100.00%	10,336	10,336	18
19	V	21	Office & Clerical - Other		Covenant Living Communities & Services	100.00%	135,772	135,772	19
20	V	23	Inservice Training & Education		Covenant Living Communities & Services	100.00%	212	212	20
21	V	24	Travel and Seminar		Covenant Living Communities & Services	100.00%	14,458	14,458	21
22	V	25	Other Admin Transportation		Covenant Living Communities & Services	100.00%	13,309	13,309	22
23	V	26	Insurance		Covenant Living Communities & Services	100.00%	3,349	3,349	23
24	V	30	Depreciation		Covenant Living Communities & Services	100.00%	38,684	38,684	24
25	V	31	Amortization		Covenant Living Communities & Services	100.00%	0		25
26	V	32	Interest		Covenant Living Communities & Services	100.00%	0		26
27	V	36	Other Property Cost		Covenant Living Communities & Services	100.00%	6,244	6,244	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 917,987			\$ 325,788	\$ * (592,199)	39

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number

Michaelson Health Center

0025577

Report Period Beginning:

10/01/19

Ending:

09/30/20

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	Board of Directors				Cov. Liv. Comm.			2
3					& Services	Skokie, IL	Home Office	3
4	Mark Eastburg		Brandel Manor	Turlock , CA	Brandel Manor	Turlock, CA	Asst. Living	4
5	Matthew Manlove		Brandel Health and Rehab	Northbrook, IL	Covenant Living			5
6	Sarah Bentley		Colonial Acres Healthcare	Golden Valley, MN	of Northbrook	Northbrook, IL	Asst. & Ind. Living	6
7	Pamela Christensen		Covenant Shores HC	Mercer Island, WA	Covenant Living			7
8	Kara Davis		Covenant Village Care Center	Plantation, FL	of Golden Valley	Golden Valley, MN	Asst. & Ind. Living	8
9	Andrew Vanover		Covenant Village Care Center	Turlock, CA	Covenant Living			9
10	Dale Rinard		Village Care and Rehab Center	Westminister, CO	at the Shores	Mercer Island, WA	Asst. & Ind. Living	10
11	Mary Palmer		Michaelson Health Center	Batavia, IL	Covenant Living			11
12	Robert Martin		Mount Miguel Covenant Village	Spring Valley, CA	of Florida	Plantation, FL	Asst. & Ind. Living	12
13	Kurt Kincanon		The Samarkand	Santa Barbara, CA	Covenant Living			13
14	Janet Creaney		Covenant Living at Windsor Park	Carol Stream, IL	of Turlock	Turlock, CA	Asst. & Ind. Living	14
15	John Fredrickson		Covenant Village of Great Lakes	Grand Rapids, MI	Covenant Living			15
16	Terri Cunliffe		Pilgrim Manor	Cromwell, CT	of Colorado	Westminister, CO	Asst. & Ind. Living	16
17	Roger Oxendale		Inverness Village	Tulsa, OK	Covenant Living			17
18	John Wenrich				at the Holmstad	Batavia, IL	Asst. & Ind. Living	18
19					Covenant Living			19
20					at Mount Miguel	Spring Valley, CA	Asst. & Ind. Living	20
21					Covenant Living			21
22					at the Samarkand	Santa Barbara, CA	Asst. & Ind. Living	22
23					Covenant Living			23
24					at Windsor Park	Carol Stream, IL	Asst. & Ind. Living	24
25					Covenant Living			25
26					at Greak Lakes	Grand Rapids, MI	Asst. & Ind. Living	26
27					Covenant Living			27
28					of Cromwell	Cromwell, CT	Asst. & Ind. Living	28
29					Covenant Living			29
30					of Geneva	Geneva, IL	Ind. Living	30

SEE ACCOUNTANTS' PREPARATION REPORT

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					Covenant Living			2
3					at Inverness	Tulsa, OK	Asst. & Ind. Living	3
4					Covenant Living			4
5					at Bixby	Bixby, OK	Asst. & Ind. Living	5
6					Cov. Care at Home	St. Charles, IL	HH & Hospice	6
7					Cov. Care at Home	Turlock, CA	HH & Hospice	7
8					Cov. Home			8
9					of Chicago	Chicago, IL	Supportive Living	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

SEE ACCOUNTANTS' PREPARATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

Ending: 09/30/20

(773) 878 - 2289

Ending: 09/30/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	2012A Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2012	\$	10,236,505	2034	4.5-5.0%	\$ 507,871	1	
2	2012C Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2012		787,533	2023	2.0-5.0%	42,375	2	
3	2017 Illinois Rev Bonds		X	Capital Imp. / Debt Refinance		2017		180,982	2029	3.24%	9,178	3	
4	2018A Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2018		3,302,763	2049	5.00%	165,139	4	
5	Capitalized Interest										(165,139)	5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	14,507,783			\$ 559,424	9	
	B. Non-Facility Related*												
10												10	
11	Interest Income										(314,063)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$				\$ (314,063)	14	
15	TOTALS (line 9+line14)						\$	14,507,783			\$ 245,361	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.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 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 2020 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:	2015		8	
	2016		9	
	2017		10	
	2018		11	
	2019		12	
Michaelson Health Center is not subject to real estate taxes.		13	FOR BHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2019 \$	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

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Michaelsen Health Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0025577

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 2019 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 2019.

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

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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.

A. Square Feet:

36,884

B. General Construction Type:

Exterior

Brick Masonry

Frame

Steel

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

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

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

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1980	\$ 85,758	1
2	CLCS (Allocation)			60,661	2
3	TOTALS			\$ 146,419	3

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Michaelsen Health Center

#

0025577

Report Period Beginning:

10/01/19

Ending:

09/30/20

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99		1980	1980	\$ 2,546,788	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1982		4,706					9
10	Various		1983		16,662					10
11	Various		1984		832					11
12	Various		1986		14,644					12
13	Various		1987		12,021					13
14	Various		1988		9,128					14
15	Various		1989		15,226					15
16	Various		1990		40,083					16
17	Various		1991		18,354					17
18	Various		1992		18,931					18
19	Various		1993		90,076					19
20	Various		1994		56,935					20
21	Various		1995		84,370					21
22	Various		1996		9,674					22
23	Various		1997		4,570					23
24	Various		1998		5,750					24
25	Various		1999		5,092					25
26	Various		2000		9,810					26
27	Various		2002		1,541					27
28	Various		2004		8,747,969					28
29	Various		2005		20,996					29
30	Various		2008		126,294					30
31	Various		2009		56,450					31
32	Various		2010		117,342					32
33	Various		2011		88,571					33
34	Various		2012		235,902					34
35	Various		2013		17,392					35
36	Various		2014		173,667					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
SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Michaelsen Health Center

0025577

Report Period Beginning:

10/01/19

Ending:

09/30/20

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	2015	\$ 51,743	\$		\$	\$	\$	37
38	Various	2016	375,815						38
39	MHC Kitchen - HVAC RTU	2017	27,221						39
40	MHC Chiller	2017	5,867						40
41	MHC Exterior Sidewalk - Memorial Building	2018	6,534						41
42	MHC 1st Floor Bathrooms - Flooring	2018	2,665						42
43	MHC SNF Unit, Hallways, and Therapy Room - Fire Caulking, Painting	2018	40,229						43
44	MHC SNF Unit, Hallways, and Therapy Room - Fire Caulking, Painting	2019	7,174						44
45	MHC Boiler - Blower and Pump	2018	3,174						45
46	MHC Boiler - Blower and Pump	2019	2,984						46
47	MHC 1st Floor - Grab Bars	2018	7,300						47
48	MHC Starwell - Doors and Maglocks	2018	16,856						48
49	MHC HVAC RTU 1 and RTU 2	2018	23,035						49
50	MHC 1st and 2nd Floor Bathrooms - Tub Units	2018	17,666						50
51	MHC 1st and 2nd Floor Bathrooms - Tub Units	2019	17,383						51
52	MHC HVAC - IDF, Office & Servery	2019	38,428						52
53	MHC Fire Alarm System	2019	132,942						53
54	MHC Conference Room	2019	2,918						54
55	MHC Elevator Improvements - M2	2019	89,791						55
56	MHC 1st Floor Dining Room - HVAC RTU	2019	8,372						56
57	MHC Parking Lot Repair	2019	2,890						57
58	MHC Dry Sprinkler Replacement	2019	3,490						58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 13,434,253	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

Facility Name & ID Number Michaelsen Health Center

0025577

Report Period Beginning:

10/01/19

Ending:

09/30/20

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 13,434,253	\$		\$	\$	\$	1
2								2
3 Covenant Living Communities & Services (Allocation)								3
4								4
5 Building Improvements (TC = \$60,000)	2006	1,820						5
6 Building Improvements (TC = \$5,278,056)	2008	160,085						6
7 Building Improvements (TC = \$35,925)	2009	1,090						7
8 Building Improvements (TC = \$11,309)	2010	343						8
9 Building Improvements (TC = \$14,820)	2011	449						9
10 Building Improvements (TC = \$116,981)	2015	3,548						10
11 Building Improvements (TC = \$737,063)	2016	22,355						11
12 Building Improvements (TC = \$107,278)	2017	3,254						12
13 Building Improvements (TC = \$137,159)	2018	4,160						13
14 Building Improvements (TC = \$24,237)	2019	735						14
15 Building Improvements (TC = \$180,424)	2020	5,472						15
16 Land Improvements (TC = \$32,653)	2008	990						16
17 Land Improvements (TC = \$15,260)	2016	463						17
18 Land Improvements (TC = \$211,166)	2018	6,405						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 Depreciation - Michaelsen Health Center			596,922		596,922		12,458,263	31
32 Depreciation - Covenant Living Communities & Services			38,684		38,684			32
33								33
34 TOTAL (lines 1 thru 33)		\$ 13,645,423	\$ 635,606		\$ 635,606	\$	\$ 12,458,263	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 734,487	\$	\$	\$		\$	71
72	Current Year Purchases	49,466						72
73	Fully Depreciated Assets							73
74	CLCS (TC = \$13,247,643)	401,805						74
75	TOTALS	\$ 1,185,758	\$	\$	\$		\$	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	CLCS (TC = \$131,480)			\$ 3,988	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$ 3,988	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	14,981,587
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	635,606
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	635,606
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	12,458,263

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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.

SEE ACCOUNTANTS' PREPARATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☒ NO

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

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

9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 14,994 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

Description		Amount		Total
Building Rental				
N/A				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-	-	
Equipment Rental				
Konica Minolta (Copier)		13,908		13,908
Pitney Bowes (Postage)		1,086		1,086
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		14,994	14,994	

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

☒ 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		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	\$		\$ 305,563	\$		\$ 305,563	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			71,168			71,168	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			349,961			349,961	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				245,339		245,339	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					132,967		132,967	12
13	Other (specify): See Supplemental	39 - 03				66,239			66,239	13
14	TOTAL			\$		\$ 792,931	\$ 378,306		\$ 1,171,237	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

Michaelsen Health Center
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Page 16 Supplemental Schedule

[illegible]

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 150	\$	1
2	Cash-Patient Deposits	56,845		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 390,993)	1,062,426		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,694		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,124,115	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	85,758		13
14	Buildings, at Historical Cost	12,450,910		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,021,175		16
17	Accumulated Depreciation (book methods)	(12,458,263)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental	15,130,983		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 16,230,564	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 17,354,679	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,483,596	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	56,845		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	237,984		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	371,122		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,149,546	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	14,507,783		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 14,507,783	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 17,657,329	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (302,650)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 17,354,679	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Description		Operating		Building		Total
Line 9 - Other Current Assets						
						-
						-
						-
						-
						-
Sub-Total		-		-		-
Line 23 - Long Term Assets						
Debt Service Costs (Net - Amortization)		156,204				156,204
Bond Discount (Net - Amortization)		14,071				14,071
Designated Assets		4,123,817				4,123,817
Construction in Progress		308,604				308,604
Intercompany Receivables		10,528,287				10,528,287
Sub-Total		15,130,983		-		15,130,983
Line 36 - Other Current Liability						
Bond Premium (Net - Amortization)		371,122				371,122
						-
						-
						-
						-
Sub-Total		371,122		-		371,122
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (706,102)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (706,102)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	403,452	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)	\$ 403,452	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)	\$ (302,650)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Michaelsen Health Center

0025577

Report Period Beginning: 10/01/19

Ending:

09/30/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

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

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 11,167,375	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,167,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	233,927	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 233,927	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	3	12
13	Barber and Beauty Care	9,484	13
14	Non-Patient Meals	20,536	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	830	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		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 30,853	23
	D. Non-Operating Revenue		
24	Contributions	5,718	24
25	Interest and Other Investment Income***	314,063	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 319,781	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental</u>	340,407	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 340,407	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,092,343	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,652,900	31
32	Health Care	4,310,984	32
33	General Administration	3,029,750	33
	B. Capital Expense		
34	Ownership	1,183,245	34
	C. Ancillary Expense		
35	Special Cost Centers	1,312,881	35
36	Provider Participation Fee	199,131	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 11,688,891	40
41	Income before Income Taxes (line 30 minus line 40)**	403,452	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 403,452	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 1,702,203	44
45	Private Pay - Net Inpatient Revenue	5,747,981	45
46	Medicare - Net Inpatient Revenue	2,703,102	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>	1,014,090	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 11,167,375	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

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Page 19 Supplemental Schedule

[illegible]

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,639	1,744	\$ 110,660	\$ 63.45	1
2	Assistant Director of Nursing	1,199	1,333	53,148	39.87	2
3	Registered Nurses	35,377	37,393	1,412,001	37.76	3
4	Licensed Practical Nurses	5,247	5,762	199,912	34.69	4
5	CNAs & Orderlies	79,973	83,837	1,536,223	18.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,209	2,300	54,348	23.63	9
10	Activity Assistants	4,247	4,473	69,073	15.44	10
11	Social Service Workers	4,010	4,271	137,616	32.22	11
12	Dietician					12
13	Food Service Supervisor	557	631	14,610	23.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,891	22,177	318,154	14.35	15
16	Dishwashers	840	878	11,220	12.78	16
17	Maintenance Workers	3,246	3,588	104,091	29.01	17
18	Housekeepers	16,287	18,244	267,706	14.67	18
19	Laundry					19
20	Administrator	1,785	1,950	117,570	60.29	20
21	Assistant Administrator					21
22	Other Administrative	402	456	36,715	80.52	22
23	Office Manager					23
24	Clerical	8,319	9,125	259,315	28.42	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	1,931	2,164	70,942	32.78	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	9,510	10,414	356,858	34.27	33
34	TOTAL (lines 1 - 33)	197,669	210,740	\$ 5,130,162 *	\$ 24.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		33,500	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		51,837	10 - 03	38
39	Pharmacist Consultant		16,260	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		3,169	11 - 03	44
45	Social Service Consultant				45
46	Other(specify) <u>See Supplemental</u>		117,090		46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 221,856		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 6,367	10 - 03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides		63,441	10 - 03	52
53	TOTAL (lines 50 - 52)		\$ 69,808		53

SEE ACCOUNTANTS' PREPARATION REPORT

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Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	7	1,024	1,066	21,814	20.46		
Scheduling Coordinator	10	1,119	1,469	24,976	17.00		
Reimbursement Coordinator	10	1,930	2,100	93,887	44.71		
Hospitality Aide	10	461	461	6,552	14.21		
Chaplain	12	1,402	1,525	65,675	43.07		
Wellness Coordinator	12	33	33	812	24.61		
Driver	14	1,309	1,367	22,881	16.74		
Marketing	43	2,232	2,393	120,261	50.26		
					-		
					-		
					-		
					-		
					-		
					-		
					-		
Total		9,510	10,414	356,858	34.27		

Contracted Services

Dietary Management	1			117,090
Total				- 117,090

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description	Amount	
Kalsang Youtso	Administrator	0	\$ 117,570	Workers' Compensation Insurance	\$	62,340	IDPH License Fee	\$ 1,990	
Amanda Gosness	Exec. Director	0	33,787	Unemployment Compensation Insurance		23,359	Advertising: Employee Recruitment	33,811	
Karen Pahlke	Ass. Exec. Dir.	0	2,928	FICA Taxes		367,518	Health Care Worker Background Check	10,245	
				Employee Health Insurance		436,287	(Indicate # of checks performed _____)		
				Employee Meals			Patient Background Checks	2,650	
				Illinois Municipal Retirement Fund (IMRF)*			Dues and Subscriptions - Other	1,664	
				Retirement Benefits		142,645	Dues and Subscriptions - Associations	17,767	
				Group Life and Disability Insurance		7,686	Licenses and Permits	2,895	
				Other Benefits		23,583	CLCS (Allocation)	10,336	
TOTAL (agree to Schedule V, line 17, col. 1)									
(List each licensed administrator separately.)			\$ 154,285						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3)			\$						
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount						
Covenant Living			\$						
Communities & Services	Management Fees		917,987						
Plante Moran, PLLC	Audit / Tax Services		663						
Jeremy Brune & Assoc, LLC	Cost Reports / Consulting		2,500						
National Research	Consulting Services		4,620						
Non-Allowable	Collections		870						
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V,		
(For legal fee disclosure, see page 39 of instructions)			\$ 926,640				line 24, col. 8)		
							\$ 16,050		

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT**

****See instructions.**

Michaelsen Health Center
Medicaid Cost Report
10/01/19 - 09/30/20

Page 21 Supplemental Schedule - Seminar and Travel Schedule

[illegible]

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. IHCA-\$7,750, Leading Age-\$580, IL Aging-\$9,436
- (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. \$ 54,208 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. \$ 199,131
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? See Pg. 2 Q. E 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. \$ 20,536
- (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 (Consolidated Basis)
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.