

		FOR BHF USE					

LL 1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0039149

Facility Name: BJORKLUND HOUSE

Address: 15841 TERRACE DRIVE OAK FOREST 60452
Number City Zip Code

County: COOK

Telephone Number: (708) 687-2038 Fax # (708) 687-2762

HFS ID Number:

Date of Initial License for Current Owners: 1/24/1994

Type of Ownership:

X VOLUNTARY, NON-PROFIT
X Charitable Corp.
Trust
IRS Exemption Code 501(c)3

PROPRIETARY GOVERNMENTAL
Individual State
Partnership County
Corporation Other
"Sub-S" Corp.
Limited Liability Co.
Trust
Other

In the event there are further questions about this report, please contact:
Name: Tracy Christenson, Controller Telephone Number: 612-759-5974
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 7/1/2024 to 6/30/2025 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) TRACY CHRISTENSON
(Title) CONTROLLER

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) () Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number BJORKLUND HOUSE# 0039149Report Period Beginning: 7/1/2024 Ending: 6/30/2025

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF									8
9	SNF/PED									9
10	ICF									10
11	ICF/DD	4,822							4,822	11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	4,822							4,822	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed
bed days on column 4, line 7.) 82.57%

D. How many bed reserve days during this year were paid by the Department?

51 (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)

NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

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

YES ☐ NO ☒

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

Date started 01/13/1994

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

YES ☐ Date _____ NO ☒

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

YES ☐ NO ☒ If YES, enter certified beds.

number of certified beds _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 6/30/2025 Fiscal Year: 6/30/2025

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



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					9	10	
	A. General Services	1	2	3	4	5	6	7	8			
1	Dietary	27,488		10,048	37,536		37,536		37,536			1
2	Food Purchase		49,553		49,553		49,553		49,553			2
3	Housekeeping		12,530		12,530		12,530		12,530			3
4	Laundry		1,374		1,374		1,374		1,374			4
5	Heat and Other Utilities			23,139	23,139		23,139		23,139			5
6	Maintenance	25,013	17,029	42,162	84,204		84,204		84,204			6
7	Other (specify):*											7
8	TOTAL General Services	52,501	80,486	75,349	208,336		208,336		208,336			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	609,381	34,432	24,396	668,209		668,209		668,209			10
10a	Therapy											10a
11	Activities		2,117	3,876	5,993		5,993		5,993			11
12	Social Services	56,350		5,570	61,920		61,920		61,920			12
13	CNA Training											13
14	Program Transportation			4,880	4,880		4,880		4,880			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	665,731	36,549	38,722	741,002		741,002		741,002			16
	C. General Administration											
17	Administrative	119,672		16,666	136,338		136,338		136,338			17
18	Directors Fees											18
19	Professional Services			25,593	25,593		25,593		25,593			19
20	Dues, Fees, Subscriptions & Promotions			20,087	20,087		20,087		20,087			20
21	Clerical & General Office Expenses	34,089	14,762	22,271	71,122		71,122		71,122			21
22	Employee Benefits & Payroll Taxes			161,856	161,856		161,856		161,856			22
23	Inservice Training & Education			1,304	1,304		1,304		1,304			23
24	Travel and Seminar			(1,504)	(1,504)		(1,504)		(1,504)			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,770	43,770		43,770		43,770			26
27	Other (specify):*											27
28	TOTAL General Administration	153,761	14,762	290,043	458,566		458,566		458,566			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	871,993	131,797	404,114	1,407,904		1,407,904		1,407,904			29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	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			43,825	43,825		43,825		43,825			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,487	6,487		6,487		6,487			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			50,312	50,312		50,312		50,312			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,255	86,255		86,255		86,255			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			86,255	86,255		86,255		86,255			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	871,993	131,797	540,681	1,544,471		1,544,471		1,544,471			45

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

Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

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

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Covenant Initiatives for Care, Inc.</u>	<u>100</u>			<u>National Covenant Properties</u>		<u>Lending</u>
				<u>Covenant Ministries of Benevolence</u>		<u>Management & Sup</u>
				<u>Covenant Ability Network of Minnesota</u>		<u>Adult Foster Care</u>
				<u>Covenant Ability Network of Michigan</u>		<u>Adult Foster Care</u>

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

☒ YES ☐ NO

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

1 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		<u>Loan interest</u>	\$ <u>6,509</u>	<u>National Covenant Properties</u>		\$ <u>6,509</u>	\$	<u>1</u>
2	V		<u>Health Insurance</u>	<u>89,860</u>	<u>Covenant Ministries of Benevolence (1/2 year only)</u>		<u>89,860</u>		<u>2</u>
3	V		<u>Liability Insurance</u>	<u>52,512</u>	<u>Covenant Ministries of Benevolence</u>		<u>52,512</u>		<u>3</u>
4	V		<u>Payroll Services</u>	<u>12,047</u>	<u>Covenant Ministries of Benevolence</u>		<u>12,047</u>		<u>4</u>
5	V		<u>Executive Director Salary</u>	<u>104,696</u>	<u>Covenant Ministries of Benevolence</u>		<u>104,696</u>		<u>5</u>
6	V		<u>Executive FICA Expense</u>	<u>7,452</u>	<u>Covenant Ministries of Benevolence</u>		<u>7,452</u>		<u>6</u>
7	V		<u>Executive Benefits</u>	<u>14,433</u>	<u>Covenant Ministries of Benevolence</u>		<u>14,433</u>		<u>7</u>
8	V		<u>Travel</u>	<u>610</u>	<u>Covenant Ministries of Benevolence</u>		<u>610</u>		<u>8</u>
9	V		<u>Website Maintenance</u>	<u>1,200</u>	<u>Covenant Ministries of Benevolence</u>		<u>1,200</u>		<u>9</u>
10	V		<u>Shared Financial Services</u>	<u>25,000</u>	<u>Covenant Ability Network of Minnesota</u>		<u>25,000</u>		<u>10</u>
11	V								<u>11</u>
12	V								<u>12</u>
13	V								<u>13</u>
14	Total			\$ <u>314,319</u>			\$ <u>314,319</u>	\$ *	<u>14</u>

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

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	NATL COVENANT PROPTY	X		FIRST MORTGAGE (#910)	\$1,754.00	4/24/08	\$ 245,000	\$ 56,033	5/25/28	6.2500	\$ 4,070	1
2	NATL COVENANT PROPTY	X		VEHICLE LOAN (#912)	\$835.00	5/09/23	50,000	34,646	5/31/27	5.0000	2,418	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$2,589.00		\$ 295,000	\$ 90,679			\$ 6,487	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 295,000	\$ 90,679			\$ 6,487	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 6,509 Line # Sec D, row 32

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

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

A. Square Feet: 9,000

B. General Construction Type: Exterior BRICKFrame WOODNumber 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).
NONE

F. List the bed capacity for the building if it differs from the licensed total.

G. Have you properly capitalized all major repairs and equipment purchases?

H. Are you presently operating under a sale and leaseback arrangement?

If YES, give effective date of lease.

I. Are you presently operating under a sublease agreement?

J. 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.

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

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	16 BED ICF/DD	24,568	1994	\$ 60,000	1

2						2
3	TOTALS		24,568		\$	60,000
						3

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	16		1993	1996	\$ 428,233	\$ 10,706	40	\$ 10,706		\$ 336,607	4
5			2006	2006	462,246	11,538	40	11,538		220,411	5
6											6
7											7
8											8
	Improvement Type**										
9	Sod			1994	2,150		20			2,150	9
10	Landscaping			1994	3,441		20			3,441	10
11	Fence			1994	719		20			719	11
12	Landscaping			1994	998		20			998	12
13	Sidewalk			1997	1,566		20			1,566	13
14	Landscaping			1997	4,545		20			4,545	14
15	Landscaping			2006	15,839	792	20	792		15,430	15
16	Fence			2014	7,639	382	20	382		4,122	16
17	Plumbing			1994	250		15			250	17
18	Insulation			1994	1,800		15			1,800	18
19	Sprinklers			1994	150		15			150	19
20	Stairway Lighting			1994	345		15			345	20
21	Drywalling			1994	264		15			264	21
22	Garage			1994	8,421		20			8,421	22
23	Water Heater			1995	3,736		15			3,736	23
24	Valve/Water Heater			1996	1,900		8			1,900	24
25	Laundry Tub			1996	1,985		8			1,985	25
26	Enclose Porch			1996	1,606		8			1,606	26
27	Septic System			1997	2,268		8			2,268	27
28	Steel Door Frames			1997	3,840		8			3,840	28
29	Sprinkler System			2000	2,880		15			2,880	29
30	Carpeting			2001	4,050		8			4,050	30
31	Curtains			2001	1,968		8			1,968	31
32	Painting			2001	1,380		8			1,380	32
33	Air Conditioning			2001	2,600		8			2,600	33
34	Painting			2002	590		8			590	34
35	Sump Pump			2002	188		8			189	35
36	Air Conditioning			2001	2,450		8			2,450	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.

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	
37	Carpeting	2002	\$ 350	\$	8	\$	\$	\$ 350	37
38	New Pumps	2002	1,637		8			1,637	38
39	Water Heater	2002	3,925		8			3,925	39
40	New Valve-Fire/Sprinkler System	2002	1,245		8			1,245	40
41	Ceramic Tile for Bathroom	2004	409		15			409	41
42	Bathroom Remodel (Contract Amount)	2011	5,200	347	15	347		5,031	42
43	New Carpeting	2011	2,108		8			2,108	43
44	Painting	2011	1,024		8			1,025	44
45	New Kitchen Countertop	2012	4,400	293	15	293		3,663	45
46	Bathroom Remodel (Contract Amount)	2013	11,150	743	15	743		9,288	46
47	New Tile for Bathroom	2014	608	41	15	41		445	47
48	Sink and Faucet for Bathroom	2014	256	17	15	17		184	48
49	Outdoor Equipment Shed	2015	1,280	85	15	85		847	49
50	Remodel womens bathroom (new tub, toilet, sink, lighting and tile)	2016	10,970	731	15	731		6,427	50
51	Replace carpet in residence room with laminate flooring	2016	1,897	126	15	126		1,076	51
52	New Fence	2022	1,500	75	20	75		209	52
53	Smoke Detector	2022	2,339	156	20	156		448	53
54	Sprinkler head replacement	2022	2,267	151	15	151		434	54
55	Activity Room Flooring	2023	2,100	140	15	140		350	55
56	Kitchen Sink	2022	250		15				56
57	Kitchen Remodel-Cabinets/Trim	2022	12,790		15				57
58	Kitchen remodel-Sink/Faucet	2022	400		15				58
59	Kitchen Remodel-Countertops	2022	1,300		15				59
60	Kitchen Remodel-Microwave	2022	300		15				60
61	Kitchen Remodel-Refrigerator	2022	1,800		15				61
62	Kitchen Remodel-Under sink water filtration	2022	200		15				62
63	Kitchen remodel-Remove, Repair, Install Labor	2022	11,690		15				63
64	Plumbing labor and install of Kitchen sink rod, testing for leaks	2023	1,500		15				64
65	Reimbursement from Covenant Ministries of Benevolence	2023	(30,095)		15				65
66	Flooring & Painting improvement (Activity Room)	2023	2,878	192	15	192		344	66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,027,725	\$ 26,515		\$ 26,515	\$	\$ 672,106	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 58,034	\$ 5,911	\$ 5,911	\$	8	\$ 36,943	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	177,929					177,929	73
74								74
75	TOTALS	\$ 235,963	\$ 5,911	\$ 5,911	\$		\$ 214,872	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	General transportation	2007 Toyota Sienna	2007	\$ 25,960	\$	\$	\$		\$ 25,960	76
77	General transportation	2022 Ford Transit XL Wagon	2023	56,996	11,399	11,399			28,498	77
78	General transportation	2011 Lift Mini Bus	2011	52,775					52,775	78
79										79
80	TOTALS			\$ 135,731	\$ 11,399	\$ 11,399	\$		\$ 107,233	80

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)	\$ 1,459,419	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 43,825	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 43,825	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)	\$ 994,211	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	Land and Building - Separate building	\$ 1,013,193	\$ 22,139	\$ 411,869	86
87	Furn Equip - Separate Program	80,138	5,142	70,697	87
88	Vehicle - Separate Program	70,577		70,577	88
89					89
90					90
91	TOTALS	\$ 1,163,908	\$ 27,281	\$ 553,143	91

G. Construction-in-Progress

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

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

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

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	2. CLASSROOM PORTION:		3. CLINICAL PORTION:	
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM	☒	IN-HOUSE PROGRAM	☒
		IN OTHER FACILITY	☐	IN OTHER FACILITY	☐
		COMMUNITY COLLEGE	☐	HOURS PER CNA	<u>40</u>
		HOURS PER CNA	<u>80</u>		

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)		16,688		16,688
4	Clinical Wages (b)		8,338		8,338
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$ 25,026	\$	\$ 25,026
10	SUM OF line 9, col. 1 and 2 (e)	\$ 25,026			

- (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.

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	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	8

- (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.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number **BJORKLUND HOUSE**# **0039149**Report Period Beginning: **7/1/2024**

Ending:

6/30/2025**XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **6/30/2025**

(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	\$ 536,497	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	551,177		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	13,685		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,101,359	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	158,480		13
14	Buildings, at Historical Cost	1,945,838		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	522,408		16
17	Accumulated Depreciation (book methods)	(1,547,355)		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):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,079,372	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,180,731	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,965	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,425		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	70,537		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,236		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	ACCRUED LIABILITIES	69,056		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 236,219	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	34,646		39
40	Mortgage Payable	191,257		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 225,904	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 462,122	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,718,609	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,180,731	\$	48

***(See instructions.)**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,771,352	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,771,352	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(210,788)	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) SEPARATE DHS PROGRAM	257,038	15
16	Other (describe) Fundraising, Gala & Administrative	(98,994)	16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (52,744)	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)	\$ 1,718,609	24

* This must agree with page 17, line 47.

STATE OF ILLINOIS

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Facility Name & ID Number BJORKLUND HOUSE

0039149

Report Period Beginning: 7/1/2024

Ending: 6/30/2025

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

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

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

1		2	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,304,334	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,304,334	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements	12,907	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		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)	\$ 12,907	23
D. Non-Operating Revenue			
24	Contributions	16,432	24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,432	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Credit card rewards	10	28
28a			28a

2		Amount	
II. Expenses			
A. Operating Expenses			
31	General Services	208,336	31
32	Health Care	741,002	32
33	General Administration	458,566	33
B. Capital Expense			
34	Ownership	50,312	34
C. Ancillary Expense			
35	Special Cost Centers		35
36	Provider Participation Fee	86,255	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,544,471	40
41	Income before Income Taxes (line 30 minus line 40)**	(210,788)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (210,788)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 1,115,252.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay		48
49	Medicare Part A		49
50	Other-(specify) SSI/SSA	189,082.00	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54

29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 10	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,333,683	30

55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,304,334	56

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		1,315	\$ 55,628	\$ 42.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses					3
4	Licensed Practical Nurses		491	15,724	32.02	4
5	CNAs & Orderlies					5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook		1,447	27,488	19.00	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers		1,137	25,013	22.00	17
18	Housekeepers		440	9,405	21.38	18
19	Laundry					19
20	Administrator		3,301	119,672	36.25	20
21	Assistant Administrator					21
22	Other Administrative		1,040	34,089	32.78	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)		1,981	56,350	28.45	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)		24,740	506,592	20.48	30
31	Medical Records					31
32	Other Health Care(specify)		1,049	22,032	21.00	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		36,941	\$ 871,993 *	\$ 23.61	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		\$ 8,897	L1,C3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant		4,960	L10,C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Psychologist</u>		14,230	L10,C3	46
47	<u>Dental</u>		523	L10,C3	47
48	<u>Psychiatrist</u>		3,375	L10,C3	48
49	TOTAL (lines 35 - 48)		\$ 31,985		49

C. CONTRACT NURSES

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

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.
- | Association Name | Amount |
|---|---------------------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u>11,500</u> |
| <u>Other, please specify Collaborative Health Urgency Group</u> | <u>5,489</u> |
| | <u>16,989</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|---|-------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | |
| <u>Other, please specify Collaborative Health Urgency Group</u> | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|---|---------------------|
| <u>ILLINOIS ASSOC OF REHABILITATION FACILITIES (IARF)</u> | <u>11,500</u> |
| <u>Other, please specify Collaborative Health Urgency Group</u> | <u>5,489</u> |
| | <u>16,989</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 217 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 86,255
This amount is to be recorded on line 42 of Schedule V.
- (8) Are there any salary costs which have been allocated to more than one line on Schedule V

- (9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (10) 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NONE Has any meal income been offset against related costs? NO Indicate the amount. \$ NONE
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$
- c. What percent of all travel expense relates to transportation of nurses and patients? 0
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? YES
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? IN PROGRESS
Firm Name: ROCHE, SHOLZ, ROCHE & WALSH LTD
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (15) 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.

for an individual employee? NO If YES, attach an explanation of the allocation.

Legal invoice:

6/20/2025 National Covenant Properties / Peterson & Cramer \$ 7,319 related to purchase of new group home

XIX Support Schedule, Section G:

Covenant Ability Network Illinois
Transaction Detail By Account
July 2024 through June 2025

Type	Date	Num	Name	Memo	Class	Clr	Split	Debit	Credit	Balance
Other Administrative Expense										
Seminars & Workshops										
Credit Card Credit	10/30/2024	JZ	IARF, Inc	SUPERVISOR SEMINAR FOR TASHA & GLORIA...	Program...		BMO Credit C...		67.32	(67.32)
Credit Card Credit	10/30/2024	JZ	IARF, Inc	SUPERVISOR SEMINAR FOR TASHA & GLORIA...	Program...		BMO Credit C...		1,800.00	(1,867.32)
Total Seminars & Workshops								0.00	1,867.32	(1,867.32)
Total Other Administrative Expense								0.00	1,867.32	(1,867.32)
TOTAL								0.00	1,867.32	(1,867.32)

Covenant Ability Network Illinois
Transaction Detail By Account
July 2024 through June 2025

Type	Date	Num	Name	Memo	Class	Clr	Split	Debit	Credit	Balance
Other Administrative Expense										
Travel & Expense - In State										
Credit Card Char...	08/30/2024		CASEY'S	JENNIFER ZELEK	Program...		BMO Credit C...	22.69		22.69
Credit Card Char...	09/02/2024		MARRIOT HOTE...	JENNIFER ZELEK	Program...		BMO Credit C...	184.80		207.49
Credit Card Credit	09/02/2024		CASEY'S	JENNIFER ZELEK	Program...		BMO Credit C...		0.22	207.27
Credit Card Char...	09/05/2024		Shell Oil	JENNIFER ZELEK	Program...		BMO Credit C...	14.27		221.54
Credit Card Credit	09/09/2024		Shell Oil	JENNIFER ZELEK	Program...		BMO Credit C...		0.14	221.40
Credit Card Char...	12/13/2024		UBER	SHANA POOLE	Program...		BMO Credit C...	16.97		238.37
Credit Card Char...	12/13/2024		UBER	HOLLY HICKMAN	Program...		BMO Credit C...	19.28		257.65

(1,504.38)

Credit Card Char...	12/13/2024		UBER	HOLLY HICKMAN	Program...	BMO Credit C...	5.00		262.65
Credit Card Char...	12/13/2024		UBER	HOLLY HICKMAN	Program...	BMO Credit C...	44.34		306.99
Credit Card Char...	12/16/2024		UBER	SHANA POOLE	Program...	BMO Credit C...	22.39		329.38
Total Travel & Expense - In State							329.74	0.36	329.38
Total Other Administrative Expense							329.74	0.36	329.38
TOTAL							329.74	0.36	329.38

Covenant Ability Network Illinois
Transaction Detail By Account
July 2024 through June 2025

Type	Date	Num	Name	Memo	Class	Clr	Split	Debit	Credit	Balance
Other Administrative Expense										
Travel & Expense - Out of State										
Credit Card Char...	07/22/2024		Murphy's USA	JENNIFER ZELEK	Program...		BMO Credit C...	13.33		13.33
Credit Card Char...	07/31/2024		Shell Oil	JENNIFER ZELEK	Program...		BMO Credit C...	20.23		33.56
Total Travel & Expense - Out of State							33.56	0.00	33.56	
Total Other Administrative Expense							33.56	0.00	33.56	
TOTAL							33.56	0.00	33.56	