

		FOR BHF USE					

LL1

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: 0034652 Facility Name: Covenant Living Windsor Park Address: 110 Windsor Park Dr Carol Stream 60188 County: DuPage Telephone Number: (630) 510 - 5200 Fax # (630) 682 - 4609 HFS ID Number: Date of Initial License for Current Owners: 03/15/85 Type of Ownership: X VOLUNTARY,NON-PROFIT X Charitable Corp. Trust IRS Exemption Code 501(c)(3) PROPRIETARY Individual Partnership Corporation "Sub-S" Corp. Limited Liability Co. Trust Other GOVERNMENTAL State County Other In the event there are further questions about this report, please contact: Name:Jeremy M. Brune, CPA Telephone Number:(779) 875 - 3979 Email Address:	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/24 to 09/30/25 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) (Type or Print Name) Elizabeth McLaren (Title) SVP - Revenue Cycle, Reimbursement, and HCBS Paid Preparer (Signed) (Print Name and Title) Jeremy M. Brune, CPA CEO (Firm Name & Address) Jeremy Brune & Associates, LLC 2508 Riverwalk Drive Plainfield, Illinois 60586 (Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355 MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 2200 Churchill Rd. Springfield, IL 62702-3406 Phone # (217) 782-1630
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Facility Name & ID Number

Covenant Living Windsor Park

#

0034652

Report Period Beginning:

10/01/24

Ending:

09/30/25

III. STATISTICAL DATA

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

N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	80	Skilled (SNF)	80	29,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,200	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	845	1,383			6,811	6,882	4,680	20,601	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	845	1,383			6,811	6,882	4,680	20,601	14

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

70.55%

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

0

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

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

N/A

F. Does the facility maintain a daily midnight census?

Yes

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

YES

NO

X

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

YES

NO

X

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

Date started

03/15/85

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

YES

Date

NO

X

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

YES

X

NO

If YES, enter certified beds.

number of certified beds

80

Medicare Intermediary

National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL

X

MODIFIED CASH*

CASH*

Is your fiscal year identical to your tax year?

YES

X

NO

Tax Year:

09/30/25

Fiscal Year:

09/30/25

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

Facility Name & ID Number Covenant Living Windsor Park # 0034652 Report Period Beginning: 10/01/24 Ending: 09/30/25

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	610,212	34,352	52,366	696,930		696,930		696,930			1
2	Food Purchase		369,806		369,806		369,806	(9,074)	360,732			2
3	Housekeeping	274,961	5,362		280,323		280,323		280,323			3
4	Laundry	33,049	4,699		37,748		37,748		37,748			4
5	Heat and Other Utilities			114,999	114,999		114,999	(15,550)	99,450			5
6	Maintenance	144,762	515	87,193	232,470		232,470	5,729	238,199			6
7	Other (specify):* See Supplemental	20,424			20,424		20,424		20,424			7
8	TOTAL General Services	1,083,408	414,734	254,558	1,752,700		1,752,700	(18,895)	1,733,806			8
	B. Health Care and Programs											
9	Medical Director			42,000	42,000		42,000		42,000			9
10	Nursing and Medical Records	3,961,375	107,943	32,015	4,101,333		4,101,333		4,101,333			10
10a	Therapy											10a
11	Activities	211,947		23,998	235,945		235,945		235,945			11
12	Social Services	266,715		36,000	302,715		302,715		302,715			12
13	CNA Training											13
14	Program Transportation	28,536	187	1,034	29,757		29,757	(5,536)	24,221			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	4,468,573	108,130	135,047	4,711,750		4,711,750	(5,536)	4,706,214			16
	C. General Administration											
17	Administrative	169,133		973,393	1,142,526		1,142,526	(769,886)	372,640			17
18	Directors Fees											18
19	Professional Services			9,890	9,890		9,890	75,045	84,935			19
20	Dues, Fees, Subscriptions & Promotions			69,274	69,274		69,274	16,611	85,885			20
21	Clerical & General Office Expenses	291,632	10,495	135,639	437,766		437,766	403,252	841,018			21
22	Employee Benefits & Payroll Taxes			1,393,140	1,393,140		1,393,140	(5,417)	1,387,723			22
23	Inservice Training & Education			792	792		792		792			23
24	Travel and Seminar			(870)	(870)		(870)	4,913	4,043			24
25	Other Admin. Staff Transportation			529	529		529	21,896	22,425			25
26	Insurance-Prop.Liab.Malpractice			108,113	108,113		108,113	3,513	111,626			26
27	Other (specify):* See Supplemental							90,687	90,687			27
28	TOTAL General Administration	460,765	10,495	2,689,900	3,161,160		3,161,160	(159,386)	3,001,775			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,012,746	533,359	3,079,505	9,625,610		9,625,610	(183,816)	9,441,794			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.

Covenant Living at Windsor Park
Medicaid Cost Report
10/01/24 - 09/30/25

Page 3 Supplemental Schedule

Description		Salaries		Supplies		Other		Total
Line 7 - Other General Services								
Security		20,424						20,424
								-
								-
								-
								-
								-
								-
Sub-Total		20,424		-		-		20,424
Line 15 - Other Health Care Services								
								-
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-
Line 27 - Other General Administration								
Alloc. - CLCS (Employee Benefits)						90,687		90,687
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		90,687		90,687

Covenant Living at Windsor Park
Medicaid Cost Report
10/01/24 - 09/30/25

Page 3 Supplemental Schedule - Inservice Training and Education

Department	Education Purpose	Education Dest.	Education Date	Expenses			Total
				In-Service	Education	Travel	
Administrative and General	Training and Development - Community			788			788
Dining Services	Training and Development - Corporate			4			4
							-
							-
							-
							-
							-
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Total				792	-	-	792

Covenant Living at Windsor Park
Medicaid Cost Report
10/01/24 - 09/30/25

Page 3 Supplemental Schedule - Travel and Seminar

Department	Education Purpose	Education Dest.	Education Date	Expenses			Total
				Conferences	In-Service	Travel	
Administrative and General	Conferences and Seminars			130			130
Administrative and General	Tuition Reimbursement				(2,500)		(2,500)
Nursing Services	Tuition Reimbursement				1,500		1,500
							-
Alloc. - CLCS (Travel and Seminar)				4,913			4,913
							-
							-
							-
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							-
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							-
Total				5,043	(1,000)	-	4,043

Covenant Living at Windsor Park
Medicaid Cost Report
10/01/24 - 09/30/25

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense[illegible]

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			612,859	612,859		612,859	30,948	643,807			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			190,492	190,492		190,492	(14,770)	175,722			32
33	Real Estate Taxes			73,500	73,500		73,500		73,500			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,507	4,507		4,507		4,507			35
36	Other (specify):* See Supplemental							6,172	6,172			36
37	TOTAL Ownership			881,358	881,358		881,358	22,350	903,708			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		541,233	1,667,396	2,208,629		2,208,629		2,208,629			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			147,650	147,650		147,650		147,650			42
43	Other (specify):* See Supplemental	191,194	2,871	11,743	205,808		205,808		205,808			43
44	TOTAL Special Cost Centers	191,194	544,104	1,826,789	2,562,087		2,562,087		2,562,087			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,203,940	1,077,463	5,787,652	13,069,055		13,069,055	(161,466)	12,907,589			45

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

Covenant Living at Windsor Park
Medicaid Cost Report
09/01/24 - 08/31/25

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
Alloc. - CLCS (Other Property Costs)						6,172		6,172
Sub-Total		-		-		6,172		6,172
Line 43 - Other Special Cost Centers								
Marketing		177,106		2,871		11,743		191,720
Philanthropy		14,088						14,088
								-
								-
								-
								-
Sub-Total		191,194		2,871		11,743		205,808

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	(9,074)	02		4
5	Telephone, TV & Radio in Resident Rooms	(18,355)	05		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	(130,327)	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 Schedule	(24,488)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (182,244)		\$	30

BHF USE ONLY							
48		49		50		51	

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)	20,778		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 20,778		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (161,466)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	Political Action Committee Payments	\$ (3,496)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Transportation Revenue	(5,536)	14	4
5	Other Revenue	(2,008)	21	5
6	Maintenance Revenue	(183)	05	6
7	CIIC Insurance Adj - WC Insurance	(5,417)	22	7
8	CIIC Insurance Adj - Insurance	(7,849)	26	8
9				9
10				10
11				11
12				12
13				13
14				14
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40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(24,488)		49

Summary A

09/30/25

[illegible]

Summary B

09/30/25

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

[illegible]

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 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	17	Administration - Salary	\$	Covenant Living Communities & Services	100.00%	\$ 185,374	\$ 185,374	1
2	V	21	Office & Clerical - Salary		Covenant Living Communities & Services	100.00%	330,099	330,099	2
3	V	27	Employee Benefits		Covenant Living Communities & Services	100.00%	90,706	90,706	3
4	V	27	Employee Benefits		Covenant International Insurance Company	100.00%	(19)	(19)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 606,160	\$ * 606,160	14

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

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%	\$ 2,988	\$ 2,988	15
16	V	6	Maintenance - Other		Covenant Living Communities & Services	100.00%	5,729	5,729	16
17	V	17	Management Fees	973,393	Covenant Living Communities & Services	100.00%	18,133	(955,260)	17
18	V	19	Professional Services		Covenant Living Communities & Services	100.00%	75,045	75,045	18
19	V	20	Dues, Fees & Subscriptions		Covenant Living Communities & Services	100.00%	20,107	20,107	19
20	V	21	Office & Clerical - Other		Covenant Living Communities & Services	100.00%	205,488	205,488	20
21	V	24	Travel and Seminar		Covenant Living Communities & Services	100.00%	4,913	4,913	21
22	V	25	Other Admin Transportation		Covenant Living Communities & Services	100.00%	21,896	21,896	22
23	V	26	Insurance		Covenant Living Communities & Services	100.00%	12,251	12,251	23
24	V	30	Depreciation		Covenant Living Communities & Services	100.00%	30,948	30,948	24
25	V	32	Interest	35,781	Covenant Living Communities & Services	100.00%	21,011	(14,770)	25
26	V	36	Other Property Cost		Covenant Living Communities & Services	100.00%	6,172	6,172	26
27	V	26	Insurance		Covenant International Insurance Company	100.00%	(889)	(889)	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			\$ 1,009,174			\$ 423,792	\$ * (585,382)	39

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

Ownership Listing-1

0034652

10/01/24

09/30/25

-Owners of companies must be listed instead of company names.

Operator/Licensee

Co. /Home Office

Co. /Home Office

Percentage

1	Board of Directors							1
2								2
3								3
4	Sarah	Bentley	Rancho Palos	CA	BOD	N/A	N/A	4
5	Kathy	Buettner	Wheaton	IL	BOD	N/A	N/A	5
6	Pamela	Christensen	Rocklin	CA	BOD	N/A	N/A	6
7	Janet	Craney	Palm Harbor	FL	BOD	N/A	N/A	7
8	Lorene	Flewellen	Avondale Est	GA	BOD	N/A	N/A	8
9	John	Fredrickson	Wauwatosa	WI	BOD	N/A	N/A	9
10	Janet	Hoffman	Evanston	IL	BOD	N/A	N/A	10
11	Kurt	Kincanon	Lafayette	IL	BOD	N/A	N/A	11
12	Robert	Martin	Northbrook	IL	BOD	N/A	N/A	12
13	Jennifer	Means	Sanford	NC	BOD	N/A	N/A	13
14	Matthew	Manlove	Attleboro	MA	BOD	N/A	N/A	14
15	Al	Lopus	Mercer Island	WA	BOD	N/A	N/A	15
16	Rick	Schepard	Maryville	MI	BOD	N/A	N/A	16
17	Allen	Anderson	Santa Barbara	CA	BOD	N/A	N/A	17
18	Craig	Swanson	Grand Rapids	MI	BOD	N/A	N/A	18
19								19
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69								69
70								70
71								71
72								72
73								73
74								74
75								75

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Brandel Manor	Turlock , CA			Cov. Liv. Comm.			1
2	Brandel Health and Rehab	Northbrook, IL			& Services	Skokie, IL	Skokie, IL	2
3	Colonial Acres Healthcare	Golden Valley, MN			Brandel Manor	Turlock, CA	Turlock, CA	3
4	Covenant Shores HC	Mercer Island, WA			Covenant Living			4
5	Covenant Village Care Center	Plantation, FL			of Northbrook	Northbrook, IL	Northbrook, IL	5
6	Covenant Village Care Center	Turlock, CA			Covenant Living			6
7	Village Care and Rehab Center	Westminister, CO			of Golden Valley	Golden Valley, MN	Golden Valley, MN	7
8	Michaelsen Health Center	Batavia, IL			Covenant Living			8
9	Mount Miguel Covenant Village	Spring Valley, CA			at the Shores	Mercer Island, WA	Mercer Island, WA	9
10	The Samarkand	Santa Barbara, CA			Covenant Living			10
11	Covenant Living at Windsor Park	Carol Stream, IL			of Florida	Plantation, FL	Plantation, FL	11
12	Covenant Village of Great Lakes	Grand Rapids, MI			Covenant Living			12
13	Pilgrim Manor	Cromwell, CT			of Turlock	Turlock, CA	Turlock, CA	13
14	Inverness Village	Tulsa, OK			Covenant Living			14
15	Three Crowns Park	Evanston, IL			of Colorado	Westminister, CO	Westminister, CO	15
16	Covenant Living of Keene	Keene, NH			Covenant Living			16
17	Shannondale of Maryville Health Care	Maryville, TN			at the Holmstad	Batavia, IL	Batavia, IL	17
18					Covenant Living			18
19					at Mount Miguel	Spring Valley, CA	Spring Valley, CA	19
20					Covenant Living			20
21					at the Samarkand	Santa Barbara, CA	Santa Barbara, CA	21
22					Covenant Living			22
23					at Windsor Park	Carol Stream, IL	Carol Stream, IL	23
24					Covenant Living			24
25					of Greak Lakes	Grand Rapids, MI	Grand Rapids, MI	25
26					Covenant Living			26
27					of Cromwell	Cromwell, CT	Cromwell, CT	27
28					Covenant Living			28
29					of Geneva	Geneva, IL	Geneva, IL	29
30								30

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1					Covenant Living			1
2					at Inverness	Tulsa, OK	Asst. & Ind. Living	2
3					Covenant Living			3
4					of Bixby	Bixby, OK	Asst. & Ind. Living	4
5					Covenant Care	St. Charles, IL	HH & Hospice	5
6					Covenant Care	Turlock, CA	HH & Hospice	6
7					Cov. Home			7
8					of Chicago	Chicago, IL	Supportive Living	8
9					Three Crowns Park	Evanston, IL	Asst. & Ind. Living	9
10					Covenant Living			10
11					of Keene	Keene, NH	Asst. & Ind. Living	11
12					Shannondale of			12
13					Knoxville	Knoxville, TN	Asst. & Ind. Living	13
14					Shannondale of			14
15					Maryville	Maryville, TN	Asst. & Ind. Living	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

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

Facility Name & ID Number Covenant Living Windsor Park # 0034652 Report Period Beginning: 10/01/24 Ending: 09/30/25

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Covenant Living Communities & Services, Inc.
Street Address 5700 Old Orchard Road
City / State / Zip Code Skokie, Illinois 60077
Phone Number (773) 878 - 2294
Fax Number (773) 878 - 2289

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Administration - Salary	Operating Expenses	517,301,000	39	\$ 7,351,493	\$ 7,351,493	13,044,174	\$ 185,374	1
2	21	Office & Clerical - Salary	Operating Expenses	517,301,000	39	13,090,948	13,090,948	13,044,174	330,099	2
3	27	Employee Benefits	Operating Expenses	517,301,000	39	3,597,175		13,044,174	90,706	3
4	27	Employee Benefits	Operating Expenses	517,301,000	39	(770)		13,044,174	(19)	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 24,038,846	\$ 20,442,441		\$ 606,160	25

Facility Name & ID Number Covenant Living Windsor Park # 0034652 Report Period Beginning: 10/01/24 Ending: 09/30/25

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization Covenant Living Communities & Services, Inc.
Street Address 5700 Old Orchard Road
City / State / Zip Code Skokie, Illinois 60077
Phone Number (773) 878 - 2294
Fax Number (773) 878 - 2289

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	5	Utilities	Operating Expenses	517,301,000	39	\$ 118,497	\$	13,044,174	\$ 2,988	1
2	6	Maintenance - Other	Operating Expenses	517,301,000	39	227,208		13,044,174	5,729	2
3	17	Management Fees	Operating Expenses	517,301,000	39	719,122		13,044,174	18,133	3
4	19	Professional Services	Operating Expenses	517,301,000	39	2,976,123		13,044,174	75,045	4
5	20	Dues, Fees & Subscriptions	Operating Expenses	517,301,000	39	797,396		13,044,174	20,107	5
6	21	Office & Clerical - Other	Operating Expenses	517,301,000	39	8,149,171		13,044,174	205,488	6
7	24	Travel and Seminar	Operating Expenses	517,301,000	39	194,849		13,044,174	4,913	7
8	25	Other Admin Transportation	Operating Expenses	517,301,000	39	868,354		13,044,174	21,896	8
9	26	Insurance	Operating Expenses	517,301,000	39	485,826		13,044,174	12,251	9
10	30	Depreciation	Operating Expenses	517,301,000	39	1,227,340		13,044,174	30,948	10
11	32	Interest	Operating Expenses	517,301,000	39	833,249		13,044,174	21,011	11
12	36	Other Property Cost	Operating Expenses	517,301,000	39	244,752		13,044,174	6,172	12
13	26	Insurance	Operating Expenses	517,301,000	39	(35,272)		13,044,174	(889)	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 16,806,615	\$		\$ 423,792	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	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	2017 Illinois Rev Bonds		X	Capital Imp. / Debt Refinance		2017	\$	365,099	2027	5.019%	\$ 19,039	1	
2	2018A Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2018		3,302,763	2048	5.000%	165,139	2	
3	2020A Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2020		146,000	2040	4.000%	5,840	3	
4	Debt Costs		X	Capital Imp. / Debt Refinance				110,141			474	4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	3,924,003			\$ 190,492	9	
	B. Non-Facility Related*												
10	CLCS Alloc. - Int. Exp.	X									21,011	10	
11	CLCS Alloc. - Int. Inc.	X									(35,781)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$				\$ (14,770)	14	
15	TOTALS (line 9+line14)						\$	3,924,003			\$ 175,722	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.)

** 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

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2024 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.)		\$	73,500	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	73,500	3	
4. Real Estate Tax accrual used for 2025 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.		\$	73,500	7	
Assessed Value from Real Estate Tax Bill:		2024	7,858,350	8	
Real Estate Tax Bill for Calendar Year:		2020	71,683	9	
		2021	75,069	10	
		2022	94,883	11	
		2023	45,361	12	
		2024	73,500	13	
Covenant Living at Windsor Park receives an allocation of the real estate tax bill that is assigned for the entire campus.		14	FOR BHF USE ONLY		
		14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
		15	PLUS APPEAL COST FROM LINE 5	\$	15
		16	LESS REFUND FROM LINE 6	\$	16
		17	AMOUNT TO USE FOR RATE CALCULATION \$		17

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.

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Covenant Living Windsor Park COUNTY DuPage
FACILITY IDPH LICENSE NUMBER 0034652
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 2024 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 2024.

	(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>02 - 31 - 405 - 019</u>	<u>Nursing Home / Campus</u>	\$ <u>144,542.42</u>	\$ <u>73,500.00</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>144,542.42</u></u>	\$ <u><u>73,500.00</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? X YES NO

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

C. **Tax Bills**

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,278 **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).

Assisted Living (Separate Financial Statements)

Independent Living (Separate Financial Statements)

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

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

H. Are you presently operating under a sale and leaseback arrangement? **No**

If YES, give effective date of lease. N/A

I. Are you presently operating under a sublease agreement? **No**

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? ☐ 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				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

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

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	80		1988	1988	\$ 307,486	\$		\$	\$	\$	4
5			2003	2003	3,876,108						5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1988	370,354						9
10	Various			2006	9,002						10
11	Various			2007	180,149						11
12	Various			2008	73,476						12
13	Various			2009	22,627						13
14	Various			2010	168,603						14
15	Various			2011	110,404						15
16	Various			2012	3,645						16
17	Various			2013	213,061						17
18	Various			2014	7,200						18
19	Various			2015	188,283						19
20	Various			2016	233,342						20
21	Various			2017	242,632						21
22	Various			2018	166,733						22
23	Various			2019	35,934						23
24	Various			2020	128,047						24
25	Various			2021	196,598						25
26	HCC - Carpet (1st Floor Hall)			2022	50,861						26
27	HCC - Air Conditioning Replacement Units (R22)			2022	63,100						27
28	HCC - Resident Room Upgrade (Carpet, Paint, Electrical)			2022	3,985						28
29	HCC - Water Leak Repairs			2022	11,543						29
30	HCC - Main Sprinkler			2022	14,040						30
31	HCC - Keys and Scan			2022	9,393						31
32	HCC - Surveillance Camera			2022	9,493						32
33	HCC - Fire Alarm System			2022	119,424						33
34	HCC - Chiller Repair			2022	45,514						34
35											35
36											36

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

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

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

1 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	HCC - Heat Pump Replacement (Kitchen)	2023	\$ 8,452	\$		\$	\$	\$	37
38	HCC - Life Safety Survey Repairs	2023	70,305						38
39	HCC - SNF and Resident Room Upgrade (Flooring, Paint,								39
40	Electrical, Doors and Frames, N nstruction)	2023	1,678,068						40
41	HCC - Hallway Demolition (West 2)	2024	118,694						41
42	HCC - Compliance Repairs	2024	58,133						42
43	HCC - Dining Room Upgrades (Flooring, Paint, Electrical)	2024	217,426						43
44	HCC - Cooling Tower Repairs	2024	7,550						44
45	HCC - Ceiling Tile and Flooring	2024	98,644						45
46	HCC - Heat Exchange Plates and Gaskets	2024	34,636						46
47	HCC - Flooring Replacement	2025	202,448						47
48	HCC - Plan of Correction	2025	5,298						48
49	HCC - Vinyl Floor Replacement	2025	10,408						49
50	HCC - Roof Leak Repair	2025	4,545						50
51	HCC - SNF Design	2025	8,704						51
52	HCC - Heat Exchanger and Gaskets	2025	13,616						52
53	HCC - Emergency Light (Elevator)	2025	3,265						53
54	HCC - Dry System Lock	2025	5,833						54
55	HCC - IDPH Deficeiences	2025	47,928						55
56	HCC - Replace Door Openers (5)	2025	13,301						56
57	HCC - HVAC Repairs	2025	7,413						57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65	Depreciation			612,859		612,859		8,765,645	65
66	Depreciation - CLCS Allocation			30,948		30,948			66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 9,475,703	\$ 643,807		\$ 643,807	\$	\$ 8,765,645	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	\$ 2,095,761	\$	\$	\$		\$	71
72	Current Year Purchases	94,804						72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	\$ 2,190,565	\$	\$	\$		\$	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 11,666,268	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 643,807	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 643,807	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)	\$ 8,765,645	85

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

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

If NO, see instructions.

YES

NO

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

XNO
16. Rental Amount for movable equipment: \$4,507Description:

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

10. Effective dates of current rental agreement:

Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2026	\$
13.	/2027	\$
14.	/2028	\$

* 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.

Description		Amount		Total
Building Rental				
				-
				-
		-		-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-		-
Equipment Rental				
Dietary		1,192		1,192
Nursing		3,315		3,315
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		4,507		4,507

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)	\$			

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

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 607,082	\$		\$ 607,082	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			60,459			60,459	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			835,714			835,714	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 prescripts				388,042		388,042	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					153,191		153,191	12
13	Other (specify): See Supplemental	39 - 03				164,141			164,141	13
14	TOTAL			\$		\$ 1,667,396	\$ 541,233		\$ 2,208,629	14

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

Covenant Living at Windsor Park
Medicaid Cost Report
10/01/24 - 09/30/25

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	\$ 4,285	\$	1
2	Cash-Patient Deposits	3,255		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 118,025)	1,058,750		3
4	Supply Inventory (priced at FIFO - Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	10,284		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	8,742		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,085,316	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	11,354,260		14
15	Leasehold Improvements, at Historical Cost	88,585		15
16	Equipment, at Historical Cost	1,706,431		16
17	Accumulated Depreciation (book methods)	(8,765,645)		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 Schedule	19,696,218		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 24,079,849	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 25,165,165	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 299,835	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,255		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	89,625		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	58,288		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 451,003	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	3,924,003		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,924,003	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,375,006	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 20,790,159	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 25,165,165	\$	48

*(See instructions.)

Covenant Living at Windsor Park
Medicaid Cost Report
10/01/24 - 09/30/25

Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Accrued Interest		1,260				1,260
Other Current Receivables		7,483				7,483
						-
						-
						-
Sub-Total		8,742		-		8,742
Line 23 - Long Term Assets						
Designated Assets		2,413,134				2,413,134
Intercompany Receivable		17,283,084				17,283,084
						-
						-
						-
Sub-Total		19,696,218		-		19,696,218
Line 36 - Other Current Liability						
						-
						-
						-
						-
						-
Sub-Total		-		-		-
Line 43 - Long term Liabilities						
		-				-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 22,584,042	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 22,584,042	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,793,883)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,793,883)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 20,790,159	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Covenant Living Windsor Park

0034652

Report Period Beginning:

10/01/24

Ending:

09/30/25

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	\$ 10,445,314	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,445,314	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	751,791	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 751,791	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,066	13
14	Non-Patient Meals	9,074	14
15	Telephone, Television and Radio	199	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)	\$ 15,339	23
	D. Non-Operating Revenue		
24	Contributions	41,652	24
25	Interest and Other Investment Income***	9,513	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 51,165	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	11,563	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 11,563	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,275,172	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,752,700	31
32	Health Care	4,711,750	32
33	General Administration	3,161,160	33
	B. Capital Expense		
34	Ownership	881,358	34
	C. Ancillary Expense		
35	Special Cost Centers	2,414,437	35
36	Provider Participation Fee	147,650	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,069,055	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,793,883)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,793,883)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 188,147	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	307,937	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	3,042,166	48
49	Medicare Part A	4,611,786	49
50	Other-(specify) <u>Insurance</u>	2,295,278	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,445,314	56

Covenant Living at Windsor Park
Medicaid Cost Report
10/01/24 - 09/30/25

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[illegible]

Facility Name & ID Number Covenant Living Windsor Park# 0034652

Report Period Beginning:

10/01/24

Ending:

09/30/25

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	1,856	2,080	\$ 187,713	\$ 90.25	1
2	Assistant Director of Nursing	1,816	2,080	124,312	59.77	2
3	Registered Nurses	24,328	27,233	1,378,767	50.63	3
4	Licensed Practical Nurses	9,939	11,190	479,317	42.83	4
5	CNAs & Orderlies	51,769	58,430	1,510,522	25.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	4,030	4,495	129,021	28.70	9
10	Activity Assistants	4,087	4,423	82,925	18.75	10
11	Social Service Workers	4,625	5,321	177,962	33.45	11
12	Dietician					12
13	Food Service Supervisor	1,947	2,078	65,567	31.55	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,751	29,069	544,645	18.74	15
16	Dishwashers					16
17	Maintenance Workers	3,865	4,338	144,762	33.37	17
18	Housekeepers	12,737	14,053	274,961	19.57	18
19	Laundry	1,413	1,552	33,049	21.29	19
20	Administrator	1,723	2,018	154,875	76.75	20
21	Assistant Administrator					21
22	Other Administrative	146	165	14,258	86.41	22
23	Office Manager					23
24	Clerical	8,386	9,428	291,634	30.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Suppl.</u>	12,559	14,075	609,650	43.31	33
34	TOTAL (lines 1 - 33)	171,977	192,028	\$ 6,203,940 *	\$ 32.31	34

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		42,000	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		15,633	10 - 03	38
39	Pharmacist Consultant		11,061	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 68,694		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

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

** See instructions.

Covenant Living at Windsor Park
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Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	07	830	1,001	20,424	20.40		
Clinical Reimbursement Manager	10	1,437	1,525	71,737	47.04		
MDS Coordinator	10	2,465	2,842	130,350	45.87		
Nursing Office Manager	10	1,832	2,080	78,657	37.82		
Customer Experience Specialist	12	1,981	2,151	56,746	26.38		
Chaplain	12	619	714	32,006	44.83		
Transportation	14	1,293	1,351	28,536	21.12		
Marketing	43	1,856	2,096	177,106	84.50		
Philanthropy	43	246	315	14,088	44.72		
					-		
					-		
					-		
					-		
					-		
Total		12,559	14,075	609,650			

Contracted Services

Dietary Management	01			52,366
Total			-	52,366

Facility Name & ID Number Covenant Living Windsor Park

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>LEADING AGE</u> | <u>31,460</u> |
| <u>IL AGING SERVICES</u> | <u>9,966</u> |
| | |
| | |
| | <u>41,426</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>LEADING AGE</u> | <u>3,496</u> |
| <u>IL AGING SERVICES</u> | |
| | |
| | |
| | <u>3,496</u> Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--------------------------|---------------------|
| <u>LEADING AGE</u> | <u>34,956</u> |
| <u>IL AGING SERVICES</u> | <u>9,966</u> |
| | |
| | |
| | <u>44,922</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 51,767 Line 10 - 02
- (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. \$ 147,650
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 for an individual employee? No If YES, attach an explanation of the allocation.

- (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? Yes
- (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? Yes - See Pg. 11 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. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 9,074
- (12) 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
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Plante & Moran, PLCC
- (14) Have all costs which do not relate to the provision of long term care been adjusted out 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.