

		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: 0025577

Facility Name: Michaelsen Health Center

Address: 831 N Batavia AvenueBatavia60510

County: Kane

Telephone Number: (630) 879 - 4000Fax #: (630) 879 - 8483

HFS ID Number:

Date of Initial License for Current Owners: 05/09/80

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 - 3979Fax #: (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

Facility Name & ID Number

Michaelsen Health Center

#

0025577

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	99	Skilled (SNF)	99	36,135	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	99	TOTALS	99	36,135	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	2,491	1,909			12,028	6,244	4,046	26,718	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	2,491	1,909			12,028	6,244	4,046	26,718	14

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

73.94%

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

05/09/80

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

99

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 Michaelsen Health Center # 0025577 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	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	469,913	32,544	134,107	636,564		636,564		636,564			1
2	Food Purchase		299,478		299,478		299,478	(53,961)	245,517			2
3	Housekeeping	338,136	61,339	26	399,501		399,501		399,501			3
4	Laundry	83,128	10,542	84,866	178,536		178,536		178,536			4
5	Heat and Other Utilities			196,585	196,585		196,585	(10,562)	186,023			5
6	Maintenance	104,055	36,206	91,690	231,951		231,951	5,854	237,805			6
7	Other (specify):* See Supplemental	23,854			23,854		23,854		23,854			7
8	TOTAL General Services	1,019,086	440,109	507,274	1,966,469		1,966,469	(58,669)	1,907,800			8
	B. Health Care and Programs											
9	Medical Director			38,000	38,000		38,000		38,000			9
10	Nursing and Medical Records	4,115,851	105,233	955,603	5,176,687		5,176,687		5,176,687			10
10a	Therapy											10a
11	Activities	120,364	4,069	19,246	143,679		143,679		143,679			11
12	Social Services	327,318	134	23,773	351,225		351,225		351,225			12
13	CNA Training											13
14	Program Transportation	11,457		33,896	45,353		45,353	(21,664)	23,689			14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	4,574,990	109,436	1,070,518	5,754,944		5,754,944	(21,664)	5,733,280			16
	C. General Administration											
17	Administrative	217,711		1,223,503	1,441,214		1,441,214	(1,003,645)	437,569			17
18	Directors Fees											18
19	Professional Services			42,288	42,288		42,288	66,075	108,363			19
20	Dues, Fees, Subscriptions & Promotions			51,089	51,089		51,089	21,563	72,652			20
21	Clerical & General Office Expenses	238,118	14,145	222,153	474,416		474,416	340,356	814,772			21
22	Employee Benefits & Payroll Taxes			1,296,094	1,296,094		1,296,094	(6,979)	1,289,115			22
23	Inservice Training & Education			16,018	16,018		16,018		16,018			23
24	Travel and Seminar			3,682	3,682		3,682	5,308	8,990			24
25	Other Admin. Staff Transportation			6,875	6,875		6,875	23,469	30,344			25
26	Insurance-Prop.Liab.Malpractice			28,294	28,294		28,294	10,220	38,514			26
27	Other (specify):* See Supplemental							97,972	97,972			27
28	TOTAL General Administration	455,829	14,145	2,889,996	3,359,970		3,359,970	(445,661)	2,914,309			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,049,905	563,690	4,467,788	11,081,383		11,081,383	(525,994)	10,555,389			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.

Michaelson Health Center
Medicaid Cost Report
10/01/24 - 09/30/25

Page 3 Supplemental Schedule

Description		Salaries		Supplies		Other		Total
Line 7 - Other General Services								
Security		23,854						23,854
Sub-Total		<u>23,854</u>		<u>-</u>		<u>-</u>		<u>23,854</u>
Line 15 - Other Health Care Services								
								-
								-
Sub-Total		<u>-</u>		<u>-</u>		<u>-</u>		<u>-</u>
Line 27 - Other General Administration								
Alloc. - CLCS (Employee Benefits)						97,972		97,972
								-
Sub-Total		<u>-</u>		<u>-</u>		<u>97,972</u>		<u>97,972</u>

Michaelsen Health Center
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			8,136			8,136
Chaplains	Training and Development - Community			849			849
Administrative and General	Training and Development - Corporate			7,033			7,033
							-
							-
							-
							-
							-
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							-
							-
Total				16,018	-	-	16,018

Michaelsen Health Center
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			3,192			3,192
Chaplains	Conferences and Seminars			447			447
Dining Services	Conferences and Seminars			43			43
					-		-
Alloc. - CLCS (Travel and Seminar)				5,308	-		5,308
							-
							-
							-
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Total				8,990	-	-	8,990

Michaelsen Health Center
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			225,352	225,352		225,352	33,435	258,787			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			649,404	649,404		649,404	(23,631)	625,773			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			63,277	63,277		63,277		63,277			35
36	Other (specify):* See Supplemental							6,667	6,667			36
37	TOTAL Ownership			938,033	938,033		938,033	16,471	954,504			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		559,854	989,526	1,549,380		1,549,380		1,549,380			39
40	Barber and Beauty Shops			2,036	2,036		2,036		2,036			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			430,694	430,694		430,694		430,694			42
43	Other (specify):* See Supplemental	131,196	872	12,575	144,643		144,643		144,643			43
44	TOTAL Special Cost Centers	131,196	560,726	1,434,831	2,126,753		2,126,753		2,126,753			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,181,101	1,124,416	6,840,652	14,146,169		14,146,169	(509,524)	13,636,645			45

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

Michaelsen Health Center
Medicaid Cost Report
10/01/24 - 09/30/25

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
Alloc. - CLCS (Other Property Costs)						6,667		6,667
Sub-Total		-		-		6,667		6,667
Line 43 - Other Special Cost Centers								
Marketing		131,196		872		12,575		144,643
Sub-Total		131,196		872		12,575		144,643

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	(53,961)	02		4
5	Telephone, TV & Radio in Resident Rooms	(13,433)	05		5
6	Rented Facility Space	(336)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(7,675)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(73,570)	21		18
19	Entertainment	(187)	25		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	(152,600)	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	(58,306)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (360,069)		\$	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)	(149,455)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (149,455)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (509,524)		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	\$ (159)	20	1
2	Other Expenses Related to Lobbying Activities			2
3				3
4	Transportation Revenue	(21,664)	14	4
5	Other Revenue	(12,093)	21	5
6	Maintenance Revenue	(357)	05	6
7	CIIC Insurance Adj - WC Insurance	(6,979)	22	7
8	CIIC Insurance Adj - Insurance	(2,054)	26	8
9	Non-Allowable	(15,000)	19	9
10				10
11				11
12				12
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46				46
47				47
48				48
49	Total	(58,306)		49

Summary A

09/30/25

[illegible]

Summary B

09/30/25

[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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administration - Salary	\$	Covenant Living Communities & Services	100.00%	\$ 200,268	\$ 200,268	1
2	V	21	Office & Clerical - Salary		Covenant Living Communities & Services	100.00%	356,621	356,621	2
3	V	27	Employee Benefits		Covenant Living Communities & Services	100.00%	97,993	97,993	3
4	V	27	Employee Benefits		Covenant International Insurance Company	100.00%	(21)	(21)	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			\$			\$ 654,861	\$ * 654,861	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%	\$ 3,228	\$ 3,228	15
16	V	6	Maintenance - Other		Covenant Living Communities & Services	100.00%	6,190	6,190	16
17	V	17	Management Fees	1,223,503	Covenant Living Communities & Services	100.00%	19,590	(1,203,913)	17
18	V	19	Professional Services		Covenant Living Communities & Services	100.00%	81,075	81,075	18
19	V	20	Dues, Fees & Subscriptions		Covenant Living Communities & Services	100.00%	21,722	21,722	19
20	V	21	Office & Clerical - Other		Covenant Living Communities & Services	100.00%	221,998	221,998	20
21	V	24	Travel and Seminar		Covenant Living Communities & Services	100.00%	5,308	5,308	21
22	V	25	Other Admin Transportation		Covenant Living Communities & Services	100.00%	23,656	23,656	22
23	V	26	Insurance		Covenant Living Communities & Services	100.00%	13,235	13,235	23
24	V	30	Depreciation		Covenant Living Communities & Services	100.00%	33,435	33,435	24
25	V	32	Interest	38,655	Covenant Living Communities & Services	100.00%	22,699	(15,956)	25
26	V	36	Other Property Cost		Covenant Living Communities & Services	100.00%	6,667	6,667	26
27	V	26	Insurance		Covenant International Insurance Company	100.00%	(961)	(961)	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			\$ 1,262,158			\$ 457,842	\$ * (804,316)	39

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

Ownership Listing-1

ID# 0025577

Names of individual owners must be listed. (Fu

-Names of trust beneficiaries must be listed.

Co. /Home Office

Names of trust beneficiaries must be listed.			Place of Residence		Ownership	Ownership	Ownership
First Name	M.I.	Last Name	City	State	Percentage	Percentage	Percentage
1	Board of Directors						
2							
3							
4	Sarah	Bentley	Rancho Palos	CA	BOD	N/A	N/A
5	Kathy	Buettner	Wheaton	IL	BOD	N/A	N/A
6	Pamela	Christensen	Rocklin	CA	BOD	N/A	N/A
7	Janet	Creaney	Palm Harbor	FL	BOD	N/A	N/A
8	Lorene	Flewellen	Avondale Est	GA	BOD	N/A	N/A
9	John	Fredrickson	Wauwatosa	WI	BOD	N/A	N/A
10	Janet	Hoffman	Evanston	IL	BOD	N/A	N/A
11	Kurt	Kincanon	Lafayette	IL	BOD	N/A	N/A
12	Robert	Martin	Northbrook	IL	BOD	N/A	N/A
13	Jennifer	Means	Sanford	NC	BOD	N/A	N/A
14	Matthew	Manlove	Attleboro	MA	BOD	N/A	N/A
15	Al	Lopus	Mercer Island	WA	BOD	N/A	N/A
16	Rick	Schepard	Maryville	MI	BOD	N/A	N/A
17	Allen	Anderson	Santa Barbara	CA	BOD	N/A	N/A
18	Craig	Swanson	Grand Rapids	MI	BOD	N/A	N/A
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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	Michaelson 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

Ending: 09/30/25

(773) 878 - 2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administration - Salary	Operating Expenses	517,301,000	39	\$ 7,351,493	\$ 7,351,493	14,092,206	\$ 200,268	1
2	21	Office & Clerical - Salary	Operating Expenses	517,301,000	39	13,090,948	13,090,948	14,092,206	356,621	2
3	27	Employee Benefits	Operating Expenses	517,301,000	39	3,597,175		14,092,206	97,993	3
4	27	Employee Benefits	Operating Expenses	517,301,000	39	(770)		14,092,206	(21)	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		\$ 654,861	25

Ending: 09/30/25

(**773**) 878 - 2289

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Operating Expenses	517,301,000	39	\$ 118,497	\$	14,092,206	\$ 3,228	1
2	6	Maintenance - Other	Operating Expenses	517,301,000	39	227,208		14,092,206	6,190	2
3	17	Management Fees	Operating Expenses	517,301,000	39	719,122		14,092,206	19,590	3
4	19	Professional Services	Operating Expenses	517,301,000	39	2,976,123		14,092,206	81,075	4
5	20	Dues, Fees & Subscriptions	Operating Expenses	517,301,000	39	797,396		14,092,206	21,722	5
6	21	Office & Clerical - Other	Operating Expenses	517,301,000	39	8,149,171		14,092,206	221,998	6
7	24	Travel and Seminar	Operating Expenses	517,301,000	39	194,849		14,092,206	5,308	7
8	25	Other Admin Transportation	Operating Expenses	517,301,000	39	868,354		14,092,206	23,656	8
9	26	Insurance	Operating Expenses	517,301,000	39	485,826		14,092,206	13,235	9
10	30	Depreciation	Operating Expenses	517,301,000	39	1,227,340		14,092,206	33,435	10
11	32	Interest	Operating Expenses	517,301,000	39	833,249		14,092,206	22,699	11
12	36	Other Property Cost	Operating Expenses	517,301,000	39	244,752		14,092,206	6,667	12
13	26	Insurance	Operating Expenses	517,301,000	39	(35,272)		14,092,206	(961)	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	\$		\$ 457,842	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	\$	86,449	2027	5.190%	\$ 4,508	1
2	2018A Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2018		3,302,763	2048	5.000%	165,139	2
3	2020B Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2020		10,625,546	2040	5.000%	445,061	3
4	2025A Colorado Rev Bonds		X	Capital Imp. / Debt Refinance		2025		7,664,139			184,588	4
5	Debt Costs		X	Capital Imp. / Debt Refinance				196,525			2,312	5
	Working Capital											
6	Capitalized Interest										(152,204)	6
7												7
8												8
9	TOTAL Facility Related						\$	21,875,421			\$ 649,404	9
	B. Non-Facility Related*											
10	CLCS Alloc. Int. Exp.	X									22,699	10
11	CLCS Alloc. Int. Inc.	X									(38,655)	11
12	Investment Income										(7,675)	12
13												13
14	TOTAL Non-Facility Related						\$				\$ (23,631)	14
15	TOTALS (line 9+line14)						\$	21,875,421			\$ 625,773	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.)		\$		2	
3. Under or (over) accrual (line 2 minus line 1).		\$		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.		\$		7	
Assessed Value from Real Estate Tax Bill: 2024			8		
Real Estate Tax Bill for Calendar Year: 2020			9		
			10		
			11		
			12		
			13		
Michaelsen Health Center is not subject to real estate taxes.				14	FOR BHF USE ONLY
				14	FROM R. E. TAX STATEMENT FOR 2024 \$
				15	PLUS APPEAL COST FROM LINE 5 \$
				16	LESS REFUND FROM LINE 6 \$
				17	AMOUNT TO USE FOR RATE CALCULATION \$

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	Michaelsen Health Center	COUNTY	Kane
---------------	--------------------------	--------	------

FACILITY IDPH LICENSE NUMBER 0025577

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 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 Applicable to Nursing Home</u>
1. N/A		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

YES	X	NO
-----	---	----

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

C. Tax Bills

Attach 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 provide copies of their original **second installment** tax bill.

XI. OWNERSHIP COSTS (continued)

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

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

****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	\$887,001	\$	\$	\$		\$	71
72	Current Year Purchases	788,246						72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	\$1,675,247	\$	\$	\$		\$	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)	\$17,386,099	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$258,787	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$258,787	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)	\$12,871,485	85

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

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

G. Construction-in-Progress

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

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

** 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
- ☒ NO

16. Rental Amount for movable equipment: \$ 63,277
- Description:
- See Supplemental Schedule
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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				
Administrative and General		10,235		10,235
Dietary		21,734		21,734
Nursing		31,307		31,307
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		63,277		63,277

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	\$		\$ 344,423	\$		\$ 344,423	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			95,827			95,827	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			391,865			391,865	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				444,803		444,803	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					115,051		115,051	12
13	Other (specify): See Supplemental	39 - 03				157,411			157,411	13
14	TOTAL			\$		\$ 989,526	\$ 559,854		\$ 1,549,380	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.

Michaelsen Health Center
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	\$ 2,258	\$	1
2	Cash-Patient Deposits	28,172		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 125,625)	1,061,563		3
4	Supply Inventory (priced at FIFO - Cost)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,397		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	78,604		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,173,994	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	85,758		13
14	Buildings, at Historical Cost	14,287,530		14
15	Leasehold Improvements, at Historical Cost	2,665		15
16	Equipment, at Historical Cost	1,866,372		16
17	Accumulated Depreciation (book methods)	(12,871,485)		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	17,362,288		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 20,733,128	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 21,907,122	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 347,465	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	28,172		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	110,998		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	333,054		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 819,689	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	21,875,421		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)	\$ 21,875,421	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 22,695,110	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (787,988)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 21,907,122	\$	48

*(See instructions.)

Michaelson Health Center
Medicaid Cost Report
10/01/24 - 09/30/25

Page 17 Supplemental Schedule

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Accrued Interest		64,043				64,043
Other Current Receivables		14,562				14,562
						-
						-
						-
Sub-Total		78,604		-		78,604
Line 23 - Long Term Assets						
Construction in Progress		166,078				166,078
Designated Assets		9,054,859				9,054,859
Intercompany Receivable		8,141,351				8,141,351
						-
						-
Sub-Total		17,362,288		-		17,362,288
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	\$ (116,633)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (116,633)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(671,355)	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)	\$ (671,355)	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)	\$ (787,988)	24

*

* This must agree with page 17, line 47.

Facility Name & ID Number Michaelsen Health Center

0025577

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	\$ 13,009,317	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 13,009,317	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,167	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 179,167	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	12,002	13
14	Non-Patient Meals	53,961	14
15	Telephone, Television and Radio	8	15
16	Rental of Facility Space	336	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)	\$ 66,307	23
	D. Non-Operating Revenue		
24	Contributions	66,709	24
25	Interest and Other Investment Income***	131,446	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 198,155	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	21,868	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,868	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 13,474,814	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,966,469	31
32	Health Care	5,754,944	32
33	General Administration	3,359,970	33
	B. Capital Expense		
34	Ownership	938,033	34
	C. Ancillary Expense		
35	Special Cost Centers	1,696,059	35
36	Provider Participation Fee	430,694	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 14,146,169	40
41	Income before Income Taxes (line 30 minus line 40)**	(671,355)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (671,355)	43

III. Net Inpatient Revenue detailed by Payer Source for each line			
44	Medicaid Fee for Service	\$ 596,148	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	456,863	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	5,756,505	48
49	Medicare Part A	4,282,367	49
50	Other-(specify) <u>Insurance</u>	1,917,434	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)	\$ 13,009,317	56

Michaelsen Health Center
Medicaid Cost Report
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[illegible]

Facility Name & ID Number Michaelson Health Center# 0025577

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	1,896	2,105	\$ 175,868	\$ 83.55	1
2	Assistant Director of Nursing	1,888	2,080	104,320	50.15	2
3	Registered Nurses	29,020	32,646	1,610,224	49.32	3
4	Licensed Practical Nurses	6,691	7,664	327,064	42.68	4
5	CNAs & Orderlies	58,554	65,196	1,643,422	25.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,232	1,368	42,992	31.43	9
10	Activity Assistants	3,956	4,318	77,372	17.92	10
11	Social Service Workers	4,298	4,706	182,973	38.88	11
12	Dietician					12
13	Food Service Supervisor	830	915	20,699	22.62	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,776	23,492	449,214	19.12	15
16	Dishwashers					16
17	Maintenance Workers	2,592	2,967	104,055	35.07	17
18	Housekeepers	15,991	17,704	338,136	19.10	18
19	Laundry	3,609	4,145	83,128	20.06	19
20	Administrator	1,613	1,872	167,177	89.30	20
21	Assistant Administrator					21
22	Other Administrative	466	478	50,534	105.72	22
23	Office Manager					23
24	Clerical	7,394	7,894	238,119	30.16	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	1,795	2,086	71,204	34.13	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Suppl.</u>	10,489	11,862	494,600	41.70	33
34	TOTAL (lines 1 - 33)	174,090	193,498	\$ 6,181,101 *	\$ 31.94	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		38,000	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		71,692	10 - 03	38
39	Pharmacist Consultant				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)		\$ 109,692		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 229,889	10 - 03	50
51	Licensed Practical Nurses		53,917	10 - 03	51
52	Certified Nurse Assistants/Aides		578,594	10 - 03	52
53	TOTAL (lines 50 - 52)		\$ 862,400		53

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

** See instructions.

Michaelsen Health Center
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Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	07	965	1,065	23,854	22.40		
Clinical Reimbursement Manager	10	88	104	5,220	50.19		
Reimbursement Coordinator	10	1,698	1,842	86,526	46.97		
Healthcare Scheduler	10	1,306	1,412	36,614	25.93		
MDS Nurse	10	912	1,122	55,389	49.37		
Customer Experience Specialist	12	2,048	2,350	75,401	32.09		
Chaplain	12	1,271	1,497	68,943	46.05		
Transportation	14	585	620	11,457	18.48		
Marketing	43	1,616	1,850	131,196	70.92		
					-		
					-		
					-		
					-		
					-		
					-		
Total		10,489	11,862	494,600			

Contracted Services

Dietary Management	01			134,107
Total			-	134,107

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount
Matthew Miller	Administrator	0	\$ 167,177	Workers' Compensation Insurance		\$ 89,142	IDPH License Fee		\$ 1,990
Julio Macias	Exec. Dir.	0	44,678	Unemployment Compensation Insurance		(19,364)	Advertising: Employee Recruitment		1,260
Ray Whitson	Assoc. Exec. Dir.	0	5,856	FICA Taxes		446,896	Health Care Worker Background Check (Indicate # of checks performed _____)		30,078
				Employee Health Insurance		663,461	<u>Patient Background Checks</u>		
				Employee Meals			<u>Association Dues (total from pg 22, #4)</u>		7,568
				Illinois Municipal Retirement Fund (IMRF)*			<u>Dues and Suscriptions</u>		4,681
				<u>Retirement</u>		62,489	<u>Licenses and Permits</u>		5,512
				<u>Life and Disability Insurance</u>		12,197	<u>Alloc. - CLCS (Dues and Subscriptions)</u>		21,722
				<u>Employee Recognition</u>		19,054			
				<u>Other</u>		15,241			
							Less: Public Relations Expense (		
							PAC and Lobbying payments		(159)
							All non-allowable advertising (		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 217,711	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,289,115	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 72,652
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
Covenant Living Communities & Services, Inc.			\$ 1,223,503			\$	Out-of-State Travel	\$	
							In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 1,223,503						
C. Professional Services									
Vendor/Payee	Type		Amount						
Plante and Moran, PLLC	Audit		\$ 4,528						
Jeremy Brune & Associates, LLC	Accounting		5,500						
Jordan Healthcare Group, LLC	Consulting		1,158						
Inspire Consulting Services	Consulting		2,080						
Sensible Senior Planning	Consulting		8,000						
Greenberg & Associates	Consulting		3,415						
NRC Health	Other		2,221						
Other	Other		386				Seminar Expense	3,682	
Non-Allowable	Other		15,000				<u>Alloc. - CLCS (Seminar Expense)</u>	5,308	
							Entertainment Expense (		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 42,288	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 8,990

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number Michaelsen Health Center

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
IL HEALTHCARE ASSOCIATION (IHCA)	1,430
IL AGING SERVICES	5,979
	7,409 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.

IL HEALTHCARE ASSOCIATION (IHCA)	159
IL AGING SERVICES	
	159 Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

IL HEALTHCARE ASSOCIATION (IHCA)	1,589
IL AGING SERVICES	5,979
	7,568 Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$61,003

Line10 - 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.

\$430,694

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.

\$53,961
- (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.