FOR BHF USE

LL1

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.

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

I. IDPH License ID Number: 0025577

Facility Name: Michaelsen Health Center

Address: 831 N Batavia Avenue (Number) Batavia (City) 60510 (Zip Code)

County: Kane

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

HFS ID Number:

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

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

IRS Exemption Code 501(c)(3)

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 10/01/19 to 09/30/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Jean Justie
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Jeremy M. Brune, CPA, Chief Executive Officer
(Firm Name & Address) Jeremy Brune & Associates, LLC, 2508 Riverwalk Drive Plainfield, Illinois 60586
(Telephone) (779) 875 - 3979 Fax # (866) 216 - 5355

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' PREPARATION REPORT

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

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,234	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	36,234	7

B. Census-For the entire report period.

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

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

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 05/06/80

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/06/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 99 and days of care provided 4,846

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

Page 3 Supplemental Schedule

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

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

Page 3 Supplemental Schedule - Other Staff Administration Travel Expense

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

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

V. COST CENTER EXPENSES (continued)

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Page 4 Supplemental Schedule

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

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

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(20,536)	02		4
5	Telephone, TV & Radio in Resident Rooms	(17,952)	05		5
6	Rented Facility Space	(830)	06		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(314,063)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(341,029)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(29,377)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (723,787)		$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(185,871)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (185,871)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (909,658)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' PREPARATION REPORT

Michaelsen Health Center

ID# 0025577

Report Period Beginning: 10/01/19

Ending: 09/30/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Maintenance Revenue	$ (315)	06	1
2	Transportation Revenue	(15,184)	14	2
3	Other Revenue	(1,103)	21	3
4	Collections	(870)	19	4
5	Amortization	(11,905)	31	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(29,377)		49

STATE OF ILLINOIS

Summary A

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

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(20,536)	0	0	0	0	0	0	0	0	0	0	(20,536)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(17,952)	0	1,969	0	0	0	0	0	0	0	0	(15,983)	5
6	Maintenance	(1,145)	92	5,446	0	0	0	0	0	0	0	0	4,393	6
7	Other (specify):*	0	10	0	0	0	0	0	0	0	0	0	10	7
8	**TOTAL General Services**	(39,633)	102	7,415	0	0	0	0	0	0	0	0	(32,116)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(15,184)	0	0	0	0	0	0	0	0	0	0	(15,184)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(15,184)	0	0	0	0	0	0	0	0	0	0	(15,184)	16
	C. General Administration													
17	Administrative	0	50,285	0	0	0	0	0	0	0	0	0	50,285	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(870)	0	(821,978)	0	0	0	0	0	0	0	0	(822,848)	19
20	Fees, Subscriptions & Promotions	0	0	10,336	0	0	0	0	0	0	0	0	10,336	20
21	Clerical & General Office Expenses	(342,132)	293,866	135,772	0	0	0	0	0	0	0	0	87,506	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	212	0	0	0	0	0	0	0	0	212	23
24	Travel and Seminar	0	0	14,458	0	0	0	0	0	0	0	0	14,458	24
25	Other Admin. Staff Transportation	0	0	13,309	0	0	0	0	0	0	0	0	13,309	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,349	0	0	0	0	0	0	0	0	3,349	26
27	Other (specify):*	0	62,075	0	0	0	0	0	0	0	0	0	62,075	27
28	**TOTAL General Administration**	(343,002)	406,226	(644,542)	0	0	0	0	0	0	0	0	(581,318)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(397,819)	406,328	(637,127)	0	0	0	0	0	0	0	0	(628,618)	29

STATE OF ILLINOIS

Summary B

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

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	38,684	0	0	0	0	0	0	0	0	38,684	30
31	Amortization of Pre-Op. & Org.	(11,905)	0	0	0	0	0	0	0	0	0	0	(11,905)	31
32	Interest	(314,063)	0	0	0	0	0	0	0	0	0	0	(314,063)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	6,244	0	0	0	0	0	0	0	0	6,244	36
37	**TOTAL Ownership**	(325,968)	0	44,928	0	0	0	0	0	0	0	0	(281,040)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(723,787)	406,328	(592,199)	0	0	0	0	0	0	0	0	(909,658)	45

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

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. [X] YES [ ] NO

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	Maintenance - Salary	$	Covenant Living Communities & Services	100.00%	$ 92	$ 92	1
2	V	7	Employee Benefits		Covenant Living Communities & Services	100.00%	10	10	2
3	V	17	Administration - Salary		Covenant Living Communities & Services	100.00%	50,285	50,285	3
4	V	21	Office & Clerical - Salary		Covenant Living Communities & Services	100.00%	293,866	293,866	4
5	V	27	Employee Benefits		Covenant Living Communities & Services	100.00%	62,075	62,075	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			$			$ 406,328	$ * 406,328	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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. [X] YES [ ] NO

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2	Board of Directors				Cov. Liv. Comm.			2
3					& Services	Skokie, IL	Home Office	3
4	Mark Eastburg		Brandel Manor	Turlock , CA	Brandel Manor	Turlock, CA	Asst. Living	4
5	Matthew Manlove		Brandel Health and Rehab	Northbrook, IL	Covenant Living			5
6	Sarah Bentley		Colonial Acres Healthcare	Golden Valley, MN	of Northbrook	Northbrook, IL	Asst. & Ind. Living	6
7	Pamela Christensen		Covenant Shores HC	Mercer Island, WA	Covenant Living			7
8	Kara Davis		Covenant Village Care Center	Plantation, FL	of Golden Valley	Golden Valley, MN	Asst. & Ind. Living	8
9	Andrew Vanover		Covenant Village Care Center	Turlock, CA	Covenant Living			9
10	Dale Rinard		Village Care and Rehab Center	Westminister, CO	at the Shores	Mercer Island, WA	Asst. & Ind. Living	10
11	Mary Palmer		Michaelsen Health Center	Batavia, IL	Covenant Living			11
12	Robert Martin		Mount Miguel Covenant Village	Spring Valley, CA	of Florida	Plantation, FL	Asst. & Ind. Living	12
13	Kurt Kincanon		The Samarkand	Santa Barbara, CA	Covenant Living			13
14	Janet Creaney		Covenant Living at Windsor Park	Carol Stream, IL	of Turlock	Turlock, CA	Asst. & Ind. Living	14
15	John Fredrickson		Covenant Village of Great Lakes	Grand Rapids, MI	Covenant Living			15
16	Terri Cunliffe		Pilgrim Manor	Cromwell, CT	of Colorado	Westminister, CO	Asst. & Ind. Living	16
17	Roger Oxendale		Inverness Village	Tulsa, OK	Covenant Living			17
18	John Wenrich				at the Holmstad	Batavia, IL	Asst. & Ind. Living	18
19					Covenant Living			19
20					at Mount Miguel	Spring Valley, CA	Asst. & Ind. Living	20
21					Covenant Living			21
22					at the Samarkand	Santa Barbara, CA	Asst. & Ind. Living	22
23					Covenant Living			23
24					at Windsor Park	Carol Stream, IL	Asst. & Ind. Living	24
25					Covenant Living			25
26					at Greak Lakes	Grand Rapids, MI	Asst. & Ind. Living	26
27					Covenant Living			27
28					of Cromwell	Cromwell, CT	Asst. & Ind. Living	28
29					Covenant Living			29
30					of Geneva	Geneva, IL	Ind. Living	30

SEE ACCOUNTANTS' PREPARATION REPORT

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2					Covenant Living			2
3					at Inverness	Tulsa, OK	Asst. & Ind. Living	3
4					Covenant Living			4
5					at Bixby	Bixby, OK	Asst. & Ind. Living	5
6					Cov. Care at Home	St. Charles, IL	HH & Hospice	6
7					Cov. Care at Home	Turlock, CA	HH & Hospice	7
8					Cov. Home			8
9					of Chicago	Chicago, IL	Supportive Living	9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION REPORT

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

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' PREPARATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance - Salary	Operating Expenses	369,928,000	35	$ 3,047	$ 3,047	11,220,025	$ 92	1
2	7	Employee Benefits	Operating Expenses	369,928,000	35	331		11,220,025	10	2
3	17	Administration - Salary	Operating Expenses	369,928,000	35	1,657,909	1,657,909	11,220,025	50,285	3
4	21	Office & Clerical - Salary	Operating Expenses	369,928,000	35	9,688,857	9,688,857	11,220,025	293,866	4
5	27	Employee Benefits	Operating Expenses	369,928,000	35	2,046,622		11,220,025	62,075	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					$ 13,396,766	$ 11,349,813		$ 406,328	25

SEE ACCOUNTANTS' PREPARATION REPORT

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

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Operating Expenses	369,928,000	35	$ 64,911	$	11,220,025	$ 1,969	1
2	6	Maintenance - Other	Operating Expenses	369,928,000	35	179,556		11,220,025	5,446	2
3	19	Professional Services	Operating Expenses	369,928,000	35	3,165,446		11,220,025	96,009	3
4	20	Dues, Fees & Subscriptions	Operating Expenses	369,928,000	35	340,777		11,220,025	10,336	4
5	21	Office & Clerical - Other	Operating Expenses	369,928,000	35	4,476,455		11,220,025	135,772	5
6	23	Inservice Training & Education	Operating Expenses	369,928,000	35	7,006		11,220,025	212	6
7	24	Travel and Seminar	Operating Expenses	369,928,000	35	476,672		11,220,025	14,458	7
8	25	Other Admin Transportation	Operating Expenses	369,928,000	35	438,807		11,220,025	13,309	8
9	26	Insurance	Operating Expenses	369,928,000	35	110,413		11,220,025	3,349	9
10	30	Depreciation	Operating Expenses	369,928,000	35	1,275,414		11,220,025	38,684	10
11	31	Amortization	Direct Allocation	1	1	73,316				11
12	32	Interest	Direct Allocation	1	1	922,774				12
13	36	Other Property Cost	Operating Expenses	369,928,000	35	205,861		11,220,025	6,244	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					$ 11,737,408	$		$ 325,788	25

SEE ACCOUNTANTS' PREPARATION REPORT

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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015		8
	2016		9
	2017		10
	2018		11
	2019		12

Michaelsen Health Center is not subject to real estate taxes.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Michaelsen Health Center COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0025577

CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune, CPA

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

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

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

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

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

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

C. **Tax Bills**

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

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 36,884 B. General Construction Type: Exterior Brick Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

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

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

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

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

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

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

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

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' PREPARATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2015	$ 51,743	$		$	$	$	37
38	Various	2016	375,815						38
39	MHC Kitchen - HVAC RTU	2017	27,221						39
40	MHC Chiller	2017	5,867						40
41	MHC Exterior Sidewalk - Memorial Building	2018	6,534						41
42	MHC 1st Floor Bathrooms - Flooring	2018	2,665						42
43	MHC SNF Unit, Hallways, and Therapy Room - Fire Caulking, Painting	2018	40,229						43
44	MHC SNF Unit, Hallways, and Therapy Room - Fire Caulking, Painting	2019	7,174						44
45	MHC Boiler - Blower and Pump	2018	3,174						45
46	MHC Boiler - Blower and Pump	2019	2,984						46
47	MHC 1st Floor - Grab Bars	2018	7,300						47
48	MHC Starwell - Doors and Maglocks	2018	16,856						48
49	MHC HVAC RTU 1 and RTU 2	2018	23,035						49
50	MHC 1st and 2nd Floor Bathrooms - Tub Units	2018	17,666						50
51	MHC 1st and 2nd Floor Bathrooms - Tub Units	2019	17,383						51
52	MHC HVAC - IDF, Office & Servery	2019	38,428						52
53	MHC Fire Alarm System	2019	132,942						53
54	MHC Conference Room	2019	2,918						54
55	MHC Elevator Improvements - M2	2019	89,791						55
56	MHC 1st Floor Dining Room - HVAC RTU	2019	8,372						56
57	MHC Parking Lot Repair	2019	2,890						57
58	MHC Dry Sprinkler Replacement	2019	3,490						58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 13,434,253	$		$	$	$	70

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 13,434,253	$		$	$	$	1
2									2
3	Covenant Living Communities & Services (Allocation)								3
4									4
5	Building Improvements (TC = $60,000)	2006	1,820						5
6	Building Improvements (TC = $5,278,056)	2008	160,085						6
7	Building Improvements (TC = $35,925)	2009	1,090						7
8	Building Improvements (TC = $11,309)	2010	343						8
9	Building Improvements (TC = $14,820)	2011	449						9
10	Building Improvements (TC = $116,981)	2015	3,548						10
11	Building Improvements (TC = $737,063)	2016	22,355						11
12	Building Improvements (TC = $107,278)	2017	3,254						12
13	Building Improvements (TC = $137,159)	2018	4,160						13
14	Building Improvements (TC = $24,237)	2019	735						14
15	Building Improvements (TC = $180,424)	2020	5,472						15
16	Land Improvements (TC = $32,653)	2008	990						16
17	Land Improvements (TC = $15,260)	2016	463						17
18	Land Improvements (TC = $211,166)	2018	6,405						18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31	Depreciation - Michaelsen Health Center			596,922		596,922		12,458,263	31
32	Depreciation - Covenant Living Communities & Services			38,684		38,684			32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,645,423	$ 635,606		$ 635,606	$	$ 12,458,263	34

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 734,487	$	$	$		$	71
72	Current Year Purchases	49,466						72
73	Fully Depreciated Assets							73
74	CLCS (TC = $13,247,643)	401,805						74
75	TOTALS	$ 1,185,758	$	$	$		$	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	CLCS (TC = $131,480)			$ 3,988	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$ 3,988	$	$	$		$	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)	$ 14,981,587	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 635,606	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 635,606	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)	$ 12,458,263	85	

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

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

G. Construction-in-Progress

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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 [X] NO

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

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

9. Option to Buy: [ ] YES [ ] NO Terms: *

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.	/2021	$
13.	/2022	$
14.	/2023	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 14,994 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Page 14 Supplemental Schedule

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

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

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' PREPARATION REPORT

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 305,563	$		$ 305,563	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			71,168			71,168	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			349,961			349,961	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				245,339		245,339	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					132,967		132,967	12
13	Other (specify): See Supplemental	39 - 03				66,239			66,239	13
14	TOTAL			$		$ 792,931	$ 378,306		$ 1,171,237	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Page 16 Supplemental Schedule

Description	Salaries	Supplies	Other	Total
Medical Supplies		132,967		132,967
Laboratory and Radiology			45,804	45,804
Respiratory Therapy			20,435	20,435
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total	-	132,967	66,239	199,206

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

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 09/30/20 (last day of reporting year)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

***(See instructions.)**

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

Page 17 Supplemental Schedule

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

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

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (706,102)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (706,102)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	403,452	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 403,452	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (302,650)	24 *

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,167,375	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,167,375	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	233,927	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 233,927	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	3	12
13	Barber and Beauty Care	9,484	13
14	Non-Patient Meals	20,536	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	830	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 30,853	23
	D. Non-Operating Revenue		
24	Contributions	5,718	24
25	Interest and Other Investment Income***	314,063	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 319,781	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental	340,407	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 340,407	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,092,343	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,652,900	31
32	Health Care	4,310,984	32
33	General Administration	3,029,750	33
	B. Capital Expense		
34	Ownership	1,183,245	34
	C. Ancillary Expense		
35	Special Cost Centers	1,312,881	35
36	Provider Participation Fee	199,131	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,688,891	40
41	**Income before Income Taxes (line 30 minus line 40)****	403,452	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 403,452	43

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

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Final If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Page 19 Supplemental Schedule

Description	Amount	Total
HHS COVID-19 Grant	323,805	323,805
Transportation Revenue	15,184	15,184
Maintenance Revenue	315	315
Other Revenue	1,103	1,103
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
		-
Total	340,407	340,407

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

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,639	1,744	$ 110,660	$ 63.45	1
2	Assistant Director of Nursing	1,199	1,333	53,148	39.87	2
3	Registered Nurses	35,377	37,393	1,412,001	37.76	3
4	Licensed Practical Nurses	5,247	5,762	199,912	34.69	4
5	CNAs & Orderlies	79,973	83,837	1,536,223	18.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,209	2,300	54,348	23.63	9
10	Activity Assistants	4,247	4,473	69,073	15.44	10
11	Social Service Workers	4,010	4,271	137,616	32.22	11
12	Dietician					12
13	Food Service Supervisor	557	631	14,610	23.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,891	22,177	318,154	14.35	15
16	Dishwashers	840	878	11,220	12.78	16
17	Maintenance Workers	3,246	3,588	104,091	29.01	17
18	Housekeepers	16,287	18,244	267,706	14.67	18
19	Laundry					19
20	Administrator	1,785	1,950	117,570	60.29	20
21	Assistant Administrator					21
22	Other Administrative	402	456	36,715	80.52	22
23	Office Manager					23
24	Clerical	8,319	9,125	259,315	28.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,931	2,164	70,942	32.78	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	9,510	10,414	356,858	34.27	33
34	TOTAL (lines 1 - 33)	197,669	210,740	$ 5,130,162 *	$ 24.34	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		33,500	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant		51,837	10 - 03	38
39	Pharmacist Consultant		16,260	10 - 03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,169	11 - 03	44
45	Social Service Consultant				45
46	Other(specify) See Supplemental		117,090		46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 221,856		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
Security	7	1,024	1,066	21,814	20.46		
Scheduling Coordinator	10	1,119	1,469	24,976	17.00		
Reimbursement Coordinator	10	1,930	2,100	93,887	44.71		
Hospitality Aide	10	461	461	6,552	14.21		
Chaplain	12	1,402	1,525	65,675	43.07		
Wellness Coordinator	12	33	33	812	24.61		
Driver	14	1,309	1,367	22,881	16.74		
Marketing	43	2,232	2,393	120,261	50.26		
					-		
					-		
					-		
					-		
					-		
					-		
Total		9,510	10,414	356,858	34.27		
Contracted Services							
Dietary Management	1						117,090
Total						-	117,090

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kalsang Youtso	Administrator	0	$ 117,570
Amanda Gosness	Exec. Director	0	33,787
Karen Pahlke	Ass. Exec. Dir.	0	2,928
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 154,285

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Covenant Living		$
Communities & Services	Management Fees	917,987
Plante Moran, PLLC	Audit / Tax Services	663
Jeremy Brune & Assoc, LLC	Cost Reports / Consulting	2,500
National Research	Consulting Services	4,620
Non-Allowable	Collections	870
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 926,640

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 62,340
Unemployment Compensation Insurance	23,359
FICA Taxes	367,518
Employee Health Insurance	436,287
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Benefits	142,645
Group Life and Disability Insurance	7,686
Other Benefits	23,583
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,063,418

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	33,811
Health Care Worker Background Check	10,245
(Indicate # of checks performed)	
Patient Background Checks	2,650
Dues and Subscriptions - Other	1,664
Dues and Subscriptions - Associations	17,767
Licenses and Permits	2,895
CLCS (Allocation)	10,336
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 81,358

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,592
CLCS (Allocation)	14,458
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 16,050

* Attach copy of IMRF notifications
**See instructions.

SEE ACCOUNTANTS' PREPARATION REPORT

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

Page 21 Supplemental Schedule - Seminar and Travel Schedule

Vendor	Session Title	Seminar Date	Location	Attendee	Position	Amount	Non-Allowable	Allowable
Northern Illinois University Outreach		01/31/20		Renee Sanchez	Office Manager	2,691	-	2,691
Seminar Refund		01/31/20		Kalsang Youtso	Administrator	(1,099)	-	(1,099)
								-
CLCS (Allocation)	Various	Various	Various	Various	Various	14,458	-	14,458
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
								-
Total						16,050	-	16,050

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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA-$7,750, Leading Age-$580, IL Aging-$9,436**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 - 10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **54,208** Line **10 - 02**

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **199,131**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' PREPARATION REPORT

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

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **See Pg. 2 Q. E** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **20,536**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **Ln. 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.