

		FOR BHF USE					

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2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0008425</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																																															
Facility Name: <u>Evenglow Lodge</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/14</u> to <u>12/31/14</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																																															
Address: <u>215 East Washington</u> <u>Pontiac</u> <u>61764</u>																																																	
Number City Zip Code																																																	
County: <u>Livingston</u>																																																	
Telephone Number: <u>(815) 844 - 6131</u> Fax # <u>(815) 842-3558</u>																																																	
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) <u>Mark Hovren</u></td></tr><tr><td>(Title) <u>President and CEO</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Date) _____</td></tr><tr><td>(Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>CEO</u></td></tr><tr><td>(Firm Name & Address) <u>Jeremy Brune & Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u></td></tr><tr><td>(Telephone) <u>(779) 875 - 3979</u> Fax # <u>(866) 216 - 5355</u></td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>Mark Hovren</u>	(Title) <u>President and CEO</u>	(Signed) _____	Paid Preparer	(Date) _____	(Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>CEO</u>	(Firm Name & Address) <u>Jeremy Brune & Associates, LLC</u> <u>2508 Riverwalk Drive Plainfield, Illinois 60586</u>	(Telephone) <u>(779) 875 - 3979</u> Fax # <u>(866) 216 - 5355</u>																																				
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Date of Initial License for Current Owners: <u>03/06/57</u>																																																	
Type of Ownership:																																																	
<table><tr><td>☒</td><td>VOLUNTARY, NON-PROFIT</td><td>☐</td><td>PROPRIETARY</td><td>☐</td><td>GOVERNMENTAL</td></tr><tr><td>☒</td><td>Charitable Corp.</td><td>☐</td><td>Individual</td><td>☐</td><td>State</td></tr><tr><td>☐</td><td>Trust</td><td>☐</td><td>Partnership</td><td>☐</td><td>County</td></tr><tr><td>IRS Exemption Code <u>501(c)(3)</u></td><td></td><td>☐</td><td>Corporation</td><td>☐</td><td>Other _____</td></tr><tr><td></td><td></td><td>☐</td><td>"Sub-S" Corp.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Limited Liability Co.</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Trust</td><td>☐</td><td>_____</td></tr><tr><td></td><td></td><td>☐</td><td>Other _____</td><td>☐</td><td>_____</td></tr></table>		☒	VOLUNTARY, NON-PROFIT	☐	PROPRIETARY	☐	GOVERNMENTAL	☒	Charitable Corp.	☐	Individual	☐	State	☐	Trust	☐	Partnership	☐	County	IRS Exemption Code <u>501(c)(3)</u>		☐	Corporation	☐	Other _____			☐	"Sub-S" Corp.	☐	_____			☐	Limited Liability Co.	☐	_____			☐	Trust	☐	_____			☐	Other _____	☐	_____
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		☐	Trust	☐	_____																																												
		☐	Other _____	☐	_____																																												
In the event there are further questions about this report, please contact:		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																																															
Name: <u>Jeremy M. Brune, CPA</u>																																																	
Telephone Number: <u>(779) 875 - 3979</u>																																																	
Email Address: _____																																																	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 <u>N/A</u>					
	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	<u>73</u>	Skilled (SNF)	<u>73</u>	<u>26,645</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>141</u>	Sheltered Care (SC)	<u>141</u>	<u>51,465</u>	5
6		ICF/DD 16 or Less			6
7	<u>214</u>	TOTALS	<u>214</u>	<u>78,110</u>	7

B. Census-For the entire report period.						
	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>6,423</u>	<u>13,682</u>	<u>3,169</u>	<u>23,274</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		<u>24,758</u>		<u>24,758</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>6,423</u>	<u>38,440</u>	<u>3,169</u>	<u>48,032</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.49%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by the Department? 0 (Do not include bed-hold days in Section B.)

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

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☒ NO ☐

I. On what date did you start providing long term care at this location?
Date started 03/06/57

J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 37 and days of care provided 2,476

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	521,532	25,342	13,782	560,656		560,656		560,656			1
2	Food Purchase		419,865		419,865	(52,122)	367,743	(24,798)	342,945			2
3	Housekeeping	248,532	51,170		299,702		299,702		299,702			3
4	Laundry											4
5	Heat and Other Utilities			345,991	345,991		345,991	(18,362)	327,629			5
6	Maintenance	104,508	75,358	147,392	327,258		327,258		327,258			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	874,572	571,735	507,165	1,953,472	(52,122)	1,901,350	(43,160)	1,858,190			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	1,830,882	122,988	11,544	1,965,414		1,965,414		1,965,414			10
10a	Therapy											10a
11	Activities	135,334	16,730	8,488	160,552		160,552		160,552			11
12	Social Services	34,000			34,000		34,000		34,000			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	2,000,216	139,718	44,032	2,183,966		2,183,966		2,183,966			16
	C. General Administration											
17	Administrative	118,867			118,867		118,867		118,867			17
18	Directors Fees											18
19	Professional Services			26,877	26,877		26,877	(3,989)	22,888			19
20	Dues, Fees, Subscriptions & Promotions			24,887	24,887		24,887		24,887			20
21	Clerical & General Office Expenses	261,375	32,253	283,285	576,913		576,913	(167,453)	409,460			21
22	Employee Benefits & Payroll Taxes			985,473	985,473	52,122	1,037,595		1,037,595			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,835	14,835		14,835	(3,616)	11,219			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			118,882	118,882		118,882		118,882			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	380,242	32,253	1,454,239	1,866,734	52,122	1,918,856	(175,058)	1,743,798			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,255,030	743,706	2,005,436	6,004,172		6,004,172	(218,218)	5,785,954			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**Evenglow Lodge
Medicaid Cost Report
01/01/14 - 12/31/14**

Page 3 Reclass

Description	Meals Served	Resident Meals	Employee Meals
Employees Meals			
Employees	60		
Meals Per Day	1		
Days in Year	365		
Meals Served Per Year	<u>21,900</u>		13.19%
Evenglow Lodge Residents			
Census	48,032		
Meals Per Day	3		
Meals Served Per year	<u>144,096</u>	86.81%	
Total Meals Served	<u>165,996</u>	86.81%	13.19%
Food Cost			
Page 3 Line 2 Column 2	419,865		
Pre-Allocation Adjustments			
Meal Income - Page 5	(24,798)		
Food Cost For Allocation	395,067	395,067	395,067
Allocated Food Cost		<u>342,945</u>	<u>52,122</u>

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			605,757	605,757		605,757		605,757			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			62	62		62	(62)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			605,819	605,819		605,819	(62)	605,757			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		97,915	398,217	496,132		496,132		496,132			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			165,914	165,914		165,914		165,914			42
43	Other (specify):* See Supplemental	923,916	184,516	672,486	1,780,918		1,780,918	(1,780,918)				43
44	TOTAL Special Cost Centers	923,916	282,431	1,236,617	2,442,964		2,442,964	(1,780,918)	662,046			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,178,946	1,026,137	3,847,872	9,052,955		9,052,955	(1,999,198)	7,053,757			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Page 4 Supplemental Schedule

IL478-2471

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	(24,798)	02		4
5	Telephone, TV & Radio in Resident Rooms	(18,362)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(62)	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	(3,989)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(110,223)	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	(1,841,764)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,999,198)		\$	30

BHF USE ONLY									
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,999,198)		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' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (6,367)	21	1
2	Flowers	(3,700)	21	2
3	Investment Fees	(47,163)	21	3
4	Travel and Seminar	(3,616)	24	4
5	Evenglow Inn	(1,542,632)	43	5
6	Skyline Apartments	(90,777)	43	6
7	Development and Marketing	(135,979)	43	7
8	Wellness Program	(11,530)	43	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	(1,841,764)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/14

Ending:

12/31/14

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(24,798)	0	0	0	0	0	0	0	0	0	0	(24,798)	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	(18,362)	0	0	0	0	0	0	0	0	0	0	(18,362)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(43,160)	0	0	0	0	0	0	0	0	0	0	(43,160)	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	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,989)	0	0	0	0	0	0	0	0	0	0	(3,989)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(167,453)	0	0	0	0	0	0	0	0	0	0	(167,453)	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	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,616)	0	0	0	0	0	0	0	0	0	0	(3,616)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(175,058)	0	0	0	0	0	0	0	0	0	0	(175,058)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(218,218)	0	0	0	0	0	0	0	0	0	0	(218,218)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(62)	0	0	0	0	0	0	0	0	0	0	(62)	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	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(62)	0	0	0	0	0	0	0	0	0	0	(62)	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):*	(1,780,918)	0	0	0	0	0	0	0	0	0	0	(1,780,918)	43
44	TOTAL Special Cost Centers	(1,780,918)	0	0	0	0	0	0	0	0	0	0	(1,780,918)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(1,999,198)	0	0	0	0	0	0	0	0	0	0	(1,999,198)	45

Facility Name & ID Number	Evenglow Lodge	#	0008425	Report Period Beginning:	01/01/14	Ending:	12/31/14
--------------------------------------	-----------------------	----------	----------------	---------------------------------	-----------------	----------------	-----------------

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.

[illegible]

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	4	5	6	7	8	
Schedule V			Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Item		Name of Related Organization				
1	V			\$			\$		1
2	V								2
3	V								3
4	V								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			\$			\$	\$ *	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number

Evenglow Lodge

0008425

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	Board of Trustees							1
2								2
3	Ruth Bosman							3
4	Mary Denker							4
5	Dan Fry							5
6	Donovan Gardner							6
7	Dick Geschwind							7
8	Bert Kinate							8
9	Meri Knapp							9
10	Doug McCoy							10
11	Ray Owens							11
12	Denise Pettit							12
13	Jerry Quick							13
14	Jeanne Rapp							14
15	Wayne Taylor							15
16	John Taylor							16
17	Roger Wahls							17
18	Carol Flessner							18
19	Leah Pogenmiller							19
20								20
21								21
22								22
23	None of the above listed trustee							23
24	members received compensation from							24
25	Evenglow Lodge during 2014.							25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

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

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

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

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										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					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

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							\$		\$			\$	1	
2													2	
3													3	
4													4	
5													5	
	Working Capital													
6	Other		X									62	6	
7													7	
8													8	
9	TOTAL Facility Related						\$		\$			\$	62	9
	B. Non-Facility Related*													
10													10	
11	Interest Income		X									(62)	11	
12													12	
13													13	
14	TOTAL Non-Facility Related						\$		\$			\$	(62)	14
15	TOTALS (line 9+line14)						\$		\$			\$		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' COMPILATION REPORT

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

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

B. Real Estate Taxes

		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 2013 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 2014 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:		2009		8	
		2010		9	
		2011		10	
		2012		11	
		2013		12	
N/A - Non Profit Organization				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2013 \$ 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' COMPILATION REPORT

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evenglow Lodge COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008425

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 2013 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 2013.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>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 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 a copy of the original 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 150,368 B. General Construction Type: Exterior Brick Frame Brick and Concrete Number of Stories 7

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

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

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

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

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

Evenglow Lodge - 26 Sheltered Care Beds (Separate IDPH License)

Skyline Apartments - 7 Independent Living Units (7th Floor of the Memorial Building)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	72,080	1960 - 1974	\$ 77,030	1
2					2
3	TOTALS	72,080		\$ 77,030	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	214		1962	1962	\$ 103,515	\$		\$	\$	\$	4
5			1963	1963	1,794,010						5
6			1984	1984	3,561,779						6
7											7
8											8
	Improvement Type**										
9	Various			1963	71,429						9
10	Various			1964	542						10
11	Various			1965	2,354						11
12	Various			1969	1,485						12
13	Various			1974	1,865						13
14	Various			1977	5,000						14
15	Various			1978	2,670						15
16	Various			1979	2,839						16
17	Various			1980	677						17
18	Various			1981	1,368						18
19	Various			1982	11,306						19
20	Various			1984	25,366						20
21	Various			1985	2,899						21
22	Various			1986	58,125						22
23	Various			1987	9,819						23
24	Various			1988	6,792						24
25	Various			1989	57,731						25
26	Various			1990	129,555						26
27	Various			1991	82,631						27
28	Various			1992	75,578						28
29	Various			1993	48,418						29
30	Various			1994	12,155						30
31	Various			1995	91,499						31
32	Various			1996	223,735						32
33	Various			1997	131,074						33
34	Various			1998	133,503						34
35	Various			1999	17,677						35
36	Various			2000	128,114						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' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2001	\$ 12,764	\$		\$	\$	\$	37
38 Various	2002	36,542						38
39 Various	2003	29,269						39
40 Various	2004	35,991						40
41 Various	2005	140,824						41
42 Various	2006	76,473						42
43 Various	2007	88,795						43
44 Various	2008	689,569						44
45 Various	2009	1,048,639						45
46 Various - ****	2009	73,515						46
47 Various - ****	2010	640,288						47
48 Repeater for Ariel Call System - ****	2011							48
49 Boiler Header Install & Boiling Pipe Insulating - ****	2011	14,388						49
50 Showers (Rms. 306, 322, 422, and 601)	2011	18,195						50
51 Water Softner Resin	2011	7,518						51
52 Carpeting (Rms. 322, 422, 601, and 622)	2011	5,127						52
53 Fire System (Pressure Pumps, Door Closer, Check Valve)	2011	2,953						53
54 Fire System (Door Closer, Fire Dampers)	2012	2,469						54
55 Steamer Repair	2012	5,859						55
56 Chiller Repair (Circuit Replacement)	2012	4,217						56
57 Boiler Repair	2012	7,534						57
58 Driveway Grate System - ****	2012	9,696						58
59 Landscaping - ****	2012	5,391						59
60 Canopy and Architectural Costs - ****	2012	243,304						60
61 2nd / 3rd Floors (Signs, Carpeting, Wallpaper, Paint,								61
62 Consulting, Showers, Corner Guards, Concrete Work) ****	2012	98,538						62
63 Water Heaters	2012	7,626						63
64 Nurse Call System - HC Center - ****	2013	65,184						64
65 Sprinkler System Upgrade - HC Center	2013	13,595						65
66 Water Heater Expansion Packs	2013	6,904						66
67 2nd/3rd/4th Floors (Carpeting, Showers, Cabinets, Blinds)	2013	15,904						67
68 Phone System - Entire Building - ****	2013							68
69 2nd/3rd/4th Floors (Carpeting, Showers, Cabinets, Blinds)	2013	2,590						69
70 TOTAL (lines 4 thru 69)		\$ 10,205,171	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,205,171	\$		\$	\$	\$	1
2	Air Handling Unit	2013	150,300						2
3	Granny Gates - Stairwells	2013	3,311						3
4	Upgrading Cable & Wiring	2013	29,214						4
5	Ceiling Tiles - Hallways	2013	5,816						5
6	Ductwork / Dampers - Dryer Room	2013	9,060						6
7	Roof Repairs - Health Center	2013	16,120						7
8	Grease Trap	2013	2,953						8
9	Laundry Room Ejector Pumps	2013	3,387						9
10	Nurse Call System - HC Center	2013	37,829						10
11	Backflow Preventor / Recirculating Pump	2013	19,061						11
12	Brick Work - Exterior of Building	2013	6,107						12
13	Weatherstripping - Exterior Doors / Windows	2014	5,148						13
14	Hot Water Heater and Mixing Valves	2014	25,150						14
15	Carpeting (Rms. 222 - 224, 319, and 508)	2014	3,163						15
16	Elevator - Pit Ladders	2014	4,029						16
17	Nurse Call System / Wanderguard System	2014	52,737						17
18	Air Handling Unit	2014	20,527						18
19	Electrical Outlets - Resident Rooms (2nd and 3rd Floors)	2014	17,640						19
20	Plenum and Duct Work Replacement	2014	1,510,733						20
21	Elevator Upgrades	2014	9,082						21
22									22
23									23
24									24
25									25
26	**** - Line items adjusted per 06/30/13 Capital Report Audit								26
27									27
28									28
29									29
30									30
31	Financial Statement Depreciation			528,416		528,416		8,167,569	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,136,538	\$ 528,416		\$ 528,416	\$	\$ 8,167,569	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$2,140,327	\$64,041	\$64,041	\$	3 - 15	\$1,109,590	71
72	Current Year Purchases	93,543	6,502	6,502		3 - 15	6,502	72
73	Fully Depreciated Assets							73
74	Disposals							74
75	TOTALS	\$2,233,870	\$70,543	\$70,543	\$		\$1,116,092	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	Facility	Van	2012	\$17,545	\$3,509	\$3,509	\$	5	\$8,773	76
77	Facility	Bus and Hitch	2001 / 2004	46,630				5	46,630	77
78	Facility	Pick-Up Truck	2009	9,231	1,319	1,319		5	7,144	78
79	Facility	Van / Tractor	2010	12,200	1,970	1,970		5	8,896	79
80	TOTALS			\$85,606	\$6,798	\$6,798	\$		\$71,443	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$14,533,044	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$605,757	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$605,757	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)	\$9,355,104	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	Skyline Apartment	\$402,951	\$9,133	\$315,024	86
87	Evenglow Inn	4,684,822	105,236	1,501,081	87
88	303 E Madison Street	65,500	910	910	88
89		4,627			89
90					90
91	TOTALS	\$5,157,900	\$115,279	\$1,817,015	91

G. Construction-in-Progress

	Description	Cost	
92	Evenglow Inn - Redecorating	\$35,425	92
93			93
94			94
95		\$35,425	95

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		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

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. /2015 \$
13. /2016 \$
14. /2017 \$

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: \$ Description:

(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' COMPILATION REPORT

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

☒ 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
		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' COMPILATION REPORT

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

12345678											
	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		hrs	\$		\$	\$		\$	1	
2	Licensed Speech and Language Development Therapist		hrs							2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist		hrs							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				78,370		78,370	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10	
11	Academic Education		hrs							11	
12	Other (specify): See Supplemental	39 - 02					19,545		19,545	12	
13	Other (specify): See Supplemental	39 - 03				398,217			398,217	13	
14	TOTAL			\$		\$ 398,217	\$ 97,915		\$ 496,132	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' COMPILATION REPORT

Page 16 Supplemental Schedule

IL478-2471

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	\$ 855,749	\$	1
2	Cash-Patient Deposits	25,494		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 235,000)	995,999		3
4	Supply Inventory (priced at Cost - FIFO)	71,023		4
5	Short-Term Investments	4,218,215		5
6	Prepaid Insurance	108,980		6
7	Other Prepaid Expenses	59,619		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	181,161		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,516,240	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	84,441		12
13	Land	1,023,060		13
14	Buildings, at Historical Cost	16,754,313		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,909,696		16
17	Accumulated Depreciation (book methods)	(11,172,119)		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	4,469,029		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 13,068,420	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,584,660	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 345,628	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	24,023		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	328,561		30
31	Accrued Taxes Payable (excluding real estate taxes)	24,756		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,326		32
33	Accrued Interest Payable	4,850		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	449,636		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,184,780	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	629,863		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)	\$ 629,863	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,814,643	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 17,770,017	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,584,660	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Evenglow Lodge
Medicaid Cost Report
01/01/14 - 12/31/14

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Accrued Interest and Dividends	12,039	
Estates Receivable	148,839	
Settlement - Medicare	20,283	
Total	181,161	-
Line 23 - Other Long Term Assets		
Construction in Progress	35,425	
Beneficial Interest in Perpetual Trust	4,417,134	
Deferred Loan Fees (Net of Amortization)	16,470	
Total	4,469,029	-
Line 36 - Other Current Liabilities		
Skyline Apartments - Deferred Refunds	91,511	
Skyline Apartments - Refund Liabilities	358,125	
Total	449,636	-
Line 43 - Other Long Term Liabilities		
Total	-	-

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning: 01/01/14

Ending: 12/31/14

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 17,398,381	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 17,398,381	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	371,636	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)	\$ 371,636	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)	\$ 17,770,017	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	\$ 7,130,071	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,130,071	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	334	13
14	Non-Patient Meals	24,798	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	16,320	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)	\$ 41,452	23
	D. Non-Operating Revenue		
24	Contributions	209,874	24
25	Interest and Other Investment Income***	299,021	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 508,895	26
	E. Other Revenue (specify).****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,744,173	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,744,173	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,424,591	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,953,472	31
32	Health Care	2,183,966	32
33	General Administration	1,866,734	33
	B. Capital Expense		
34	Ownership	605,819	34
	C. Ancillary Expense		
35	Special Cost Centers	2,277,050	35
36	Provider Participation Fee	165,914	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,052,955	40
41	Income before Income Taxes (line 30 minus line 40)**	371,636	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 371,636	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 810,641	44
45	Private Pay - Net Inpatient Revenue	4,963,201	45
46	Medicare - Net Inpatient Revenue	1,356,229	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,130,071	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' COMPILATION REPORT

**Evenglow Lodge
Medicaid Cost Report
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Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Skyline Apartments	84,718	84,718
Evenglow Inn	1,651,458	1,651,458
Vending Commissions	814	
Silver Sneaker Program	816	
Miscellaneous Income	6,367	6,367
Total	1,744,173	1,742,543

Facility Name & ID Number Evenglow Lodge# 0008425

Report Period Beginning:

01/01/14

Ending:

12/31/14

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	1,898	2,062	\$ 77,262	\$ 37.47	1
2	Assistant Director of Nursing	3,963	4,351	112,097	25.76	2
3	Registered Nurses	12,774	13,775	335,096	24.33	3
4	Licensed Practical Nurses	16,101	17,808	410,692	23.06	4
5	CNAs & Orderlies	65,942	73,420	875,443	11.92	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,671	10,796	135,335	12.54	10
11	Social Service Workers	1,788	1,947	34,000	17.46	11
12	Dietician					12
13	Food Service Supervisor	2,022	2,225	41,777	18.78	13
14	Head Cook	1,957	2,095	26,775	12.78	14
15	Cook Helpers/Assistants	40,752	44,454	452,980	10.19	15
16	Dishwashers					16
17	Maintenance Workers	6,273	6,909	104,508	15.13	17
18	Housekeepers	24,434	25,083	248,532	9.91	18
19	Laundry					19
20	Administrator	1,720	1,957	118,867	60.74	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,996	17,372	261,374	15.05	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	1,578	1,842	20,292	11.02	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	56,471	63,315	923,916	14.59	33
34	TOTAL (lines 1 - 33)	262,340	289,411	\$ 4,178,946 *	\$ 14.44	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		\$ 13,782	01 - 03	35
36	Medical Director		24,000	09 - 03	36
37	Medical Records Consultant		2,729	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant		7,915	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		8,488	11 - 03	44
45	Social Service Consultant				45
46	Other(specify) <u>Rehab Consultant</u>		900	10 - 03	46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 57,814		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Page 20 Supplemental Schedule

HFS 3745 (N-4-99)

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	
Mark Hovren	President / CEO	0	\$ 118,867	Workers' Compensation Insurance	\$ 110,401	IDPH License Fee	\$	
				Unemployment Compensation Insurance	17,656	Advertising: Employee Recruitment	1,498	
				FICA Taxes	244,377	Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	518,150	Patient Background Checks		
				Employee Meals	52,122	Licenses and Dues	19,363	
				Illinois Municipal Retirement Fund (IMRF)*		Subscriptions	4,026	
				401K Employee Match	60,373			
				Employee Recognition	18,513			
				Employee Physicals and Drug Testing	16,003			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 118,867			Less: Public Relations Expense	()	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$			TOTAL (agree to Sch. V, line 20, col. 8)		
						\$ 24,887		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,037,595		
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Robert A. Kearney	Legal - Retainer		\$ 3,989			\$	Out-of-State Travel	\$
Polsinelli Shughart	Legal		4,037					
Jeremy Brune & Associates, LLC	Accounting / Auditing		18,851				In-State Travel	
							Seminar Expense	14,835
							Non-Allowable	(3,616)
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 26,877	TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 11,219

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

****See instructions.**

**Evenglow Lodge
Medicaid Cost Report
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Page 21 Supplemental Schedule - Legal Invoice Detail

Firm Name	Invoice Date	Description of Services	Total	Non-Allowable Amount
Polsinelli Shughart	04/30/14	IDPH Survey Matters	2,268	-
Polsinelli Shughart	07/11/14	IDPH Survey Matters	933	-
Polsinelli Shughart	09/19/14	IDPH Survey Matters	174	-
Polsinelli Shughart	09/30/14	IDPH Survey Matters	366	-
Polsinelli Shughart	12/31/14	IDPH Survey Matters	296	-
Robert A Kearney	01/03/14	Retainer	3,989	3,989
Total			8,026	3,989

Eveninglow Lodge
Medicaid Cost Report
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Page 21 Supplemental Schedule - Seminar Schedule

Name of Session	Sponsor	Attendee	Location	Total	Non-Allowable
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	19	
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	14	
Silver Sneakers Workshops	Healthways	Amy Bomarito	Downers Grove, IL	225	
Fred Pryor Seminar	fred Pryor Seminars	S Schule, K Kelly, L Petersen, C Laughlin	Bloomington, IL	316	
Annual NARPCOM Conference	NARPCOM	Mark Hovren	Nashville, TN	1,898	1,898
Leading Age Convention	Leading Age	K Abels, S Johnson, R Sullivan, R Young	Roseville, IL	1,993	
Leading Age Convention	Leading Age	Susan Johnson	Roseville, IL	186	
Leading Age Convention	Leading Age	Karen Abels	Roseville, IL	133	
Leading Age Convention	Leading Age	Roger Wahls	Roseville, IL	150	
Music and Memory Webinar	Eveninglow	Erin Vicki, Jill	Pontiac, IL	600	
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	19	
Parking Reimbursement	Eveninglow	Roy Moore	Chicago, IL	11	
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	18	
Fred Pryor Seminar	fred Pryor Seminars	Karen Abels	Bloomington	73	
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	29	
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	17	
ABE Application seminar	IDHFS	Barb Sullivan	Springfield	133	
Att. Action Webinar	Mgt Assoc	Susan & Karen	Pontiac, IL	125	
Leading Age Senior Liv Conf	Leading Age	Mark Hovren	Naperville, IL	325	
Social Acct. & commn Enngng	Leading Age	Mark & Susan	Metamora, IL	250	
Social Acct. & commn Enngng mtg	Leading Age	Susan Johnson	Metamora, IL	39	
Parking Reimbursement	Eveninglow	Roy Moore	Chicago, IL	11	
Parking Reimbursement	Eveninglow	Roy Moore	Chicago, IL	11	
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	25	
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	17	
Mileage Reimbursement	Eveninglow	Karen Abels	Pontiac, IL	23	
Leading Age Lodging - Fall Conventon	Leading Age	Mark Hovren	Liste, IL	331	
Leading Age HR Conference	Leading Age	Susan and Karen	Springfield, IL	250	
IL New perscription monitoring webinar	Leading Age	Mark, Erin, Sheila, Jill, Sue, Shelah	Pontiac, IL	99	
Continuing education courses	American Council	Amy Bomarito	Pontiac, IL	60	
Leading Age Webinar	Leading Age	Karen and Susan	Pontiac, IL	99	
AFP Central Illinois Chapter	AFP	Kathy Alexander	Peoria, IL	15	15
Mileage Reimbursement	Eveninglow	Erin Jensen	Gibson City, IL	50	50
Mileage Reimbursement	IGRC	Erin Jensen		91	91
Mileage Reimbursement	Eveninglow	Kathy Alexander	Saybrook, IL	46	46
Mileage Reimbursement	Eveninglow	Kathy Alexander	Peoria, IL	71	71
Mileage Reimbursement	AFP	Kathy Alexander	Peoria, IL	49	49
Mileage Reimbursement	Eveninglow	Kathy Alexander	Decatur, IL	55	55
Mileage Reimbursement	Eveninglow	Kathy Alexander	Waukega, IL	91	91
Mileage Reimbursement	Eveninglow	Kathy Alexander	Gibson City, IL	25	25
Mileage Reimbursement	Eveninglow	Kathy Alexander	Leavenworth, IL	3	3
Mileage Reimbursement	Eveninglow	Kathy Alexander	Champaign, IL	64	64
Mileage Reimbursement	Eveninglow	Kathy Alexander	Kankakee, IL	74	74
AFP meeting	AFP	Kathy Alexander	Peoria, IL	15	15
AFP meeting	AFP	Marilyn Groves	Peoria, IL	25	25
Mileage Reimbursement	Eveninglow	Kathy Alexander	Peoria, IL	43	43
Streator Health Fair Expo	Streator Health Fair	Darcy Woodburn	Streator, IL	28	28
Mileage Reimbursement	Eveninglow	Kathy Alexander	Dwight, IL	44	44
Mileage Reimbursement	Eveninglow	Kathy Alexander	Fairbury, IL	34	34
Mileage Reimbursement	Eveninglow	Kathy Alexander	Flanagan, IL	27	27
Evaluation and Assessment	Eveninglow	Darcy Woodburn	Peoria, IL	80	80
AFP Central Illinois Chapter	AFP	Kathy Alexander	Peoria, IL	15	15
AFP Central Illinois Chapter	AFP	Mark Hovren	Peoria, IL	25	25
Returning from Leading Age mtg	Leading Age	Kathy Alexander	Schaumburg, IL	146	146
Leading Age Workshop	Leading Age	Kathy Alexander	Schaumburg, IL	125	125
Leading Age Convention	Leading Age	Amy Bomarito	Roseville, IL	473	
CBADA lunch	CBADA	Marilyn Pritchard	Fairbury, IL	8	
CBADA lunch	CBADA	Ashley Lewis	Fairbury, IL	9	
Leading Age Convention	Leading Age	Janette Dorley	Roseville, IL	473	
Sanitation Certification	LCPI	E. Allford & J. Hildebrand	Pontiac, IL	200	
Corn belt membership	Corn belt	Marilyn, Chris		105	
Activ. Conference	IAPA	Marilyn Pritchard	Decatur, IL	140	
Golden Cross	Golden Cross	Kathy Alexander	Peoria, IL	36	36
Golden Cross	Eveninglow	Kathy Alexander	Quincy, IL	195	195
Mileage Reimbursement	AFP	Kathy Alexander	Peoria, IL	52	52
Mileage Reimbursement	Eveninglow	Kathy Alexander	Peoria, IL	68	68
Mileage Reimbursement	Eveninglow	Kathy Alexander	Urbana, IL	71	71
Mileage Reimbursement	AFP	Kathy Alexander	Peoria, IL	69	69
Leading Age Convention	Leading Age	S. Simons, S. Gaston	Roseville, IL	1,112	
LSN Clinical Serv in Post Acute Care	LSN	A Swetch, S Gaston, J O'Neill	Springfield, IL	310	
Leading Age Convention	Leading Age	Sheila Simons	Roseville, IL	106	
Medication Reduction Seminar	Cont. Ed. Inst.	Jason Fox	Bloomington, IL	116	
mtg Medication Reduction Seminar	Cont. Ed. Inst.	Jason Fox	Bloomington, IL	39	
CPR certification	Eveninglow	Sheila Simons	Pontiac, IL	9	
mtg for Do No Harm seminar	LSN	Sheila Simons	Palos Hills, IL	84	
seminar AANAC recertif	Pathway Health	Sue Schell	Orland Park, IL	413	
webinar Resident Sexuality	Mather Lifeways	Erin Jensen	Pontiac, IL	49	
webinar TB screening	Leading Age	Sheila Simons	Pontiac, IL	99	
LTC certit program	Leading Age	Sheila Simons	Peoria, IL	650	
RAC class		Sue Schell	Orland Park, IL	90	
DON Certification		Sheila Simons	Peoria, IL	68	
DON Certification		Sheila Simons	Peoria, IL	68	
DON Certification		Sheila Simons	Peoria, IL	68	
DON Certification		Sheila Simons	Peoria, IL	46	
mtg United Methodist Center	ited Methodist Cent	Mark Hovren	Springfield, IL	80	
mtg United Methodist Center	ited Methodist Cent	Mark Hovren	Springfield, IL	70	
CBADA lunch	CBADA	Marilyn Pritchard	Fairbury, IL	8	
CBADA mtg	CBADA	Marilyn Pritchard	Fairbury, IL	17	
CBADA lunch	CBADA	Marilyn Pritchard	Fairbury, IL	8	
CBADA lunch	CBADA	Vicki Middleth	Fairbury, IL	11	
IAPA Convention fees	IAPA	Marilyn Pritchard	Decatur, IL	260	
IAPA Convention hotel costs	IAPA	Marilyn Pritchard	Decatur, IL	150	
Corn Belt lunch	Corn Belt	Ashley Lewis	Fairbury, IL	9	
Corn Belt lunch	Corn Belt	Chris Harms	Fairbury, IL	9	
Ramirez consulting Act dir course	Ramirez	Chris Harms	Peoria, IL	500	
Corn Belt lunch	Corn Belt	Marilyn Pritchard	Fairbury, IL	9	
Corn Belt lunch	Corn Belt	Chris Harms	Fairbury, IL	13	
Corn Belt lunch	Corn Belt	Marilyn Pritchard	Fairbury, IL	8	
Bus trip to Festival of Trees lunch	Eveninglow	Marilyn Pritchard	Peoria, IL	8	
				122	
Total				14,835	3,616

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

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.

Leading Age / AAHSA \$8,769

(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. \$

38,440

 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.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$

165,914

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.

(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?

Yes - See Page 12

 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. \$

52,122

 Has any meal income been offset against related costs?

Yes

 Indicate the amount. \$

24,798

(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?

100 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:

Not Final - Jeremy Brune & Associates, LLC

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

Yes

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details.

Yes

Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT