

		FOR BHF USE					

LL1

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

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: 0008425

Facility Name: Evenglow Lodge

Address: 215 East Washington Pontiac 61764
Number City Zip Code

County: Livingston

Telephone Number: (815) 844-6131 Fax # (815) 842 - 3558

HFS ID Number:

Date of Initial License for Current Owners: 03/06/57

Type of Ownership:

☒ VOLUNTARY, NON-PROFIT
☒ Charitable Corp.
☐ Trust

IRS Exemption Code 501(c)(3)

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/11 to 12/31/11 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) Mark Hovren	
	(Title) Administrator	
Paid Preparer	(Signed) _____	(Date) _____
	(Print Name and Title) Jeremy M. Brune, CPA	
	(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

Facility Name & ID Number Evenglow Lodge

0008425 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

B. Census-For the entire report period.						
	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,368</u>	<u>13,128</u>	<u>2,946</u>	<u>23,442</u>	<u>8</u>
9	SNF/PED					<u>9</u>
10	ICF					<u>10</u>
11	ICF/DD					<u>11</u>
12	SC		<u>21,772</u>		<u>21,772</u>	<u>12</u>
13	DD 16 OR LESS					<u>13</u>
14	TOTALS	<u>7,368</u>	<u>34,900</u>	<u>2,946</u>	<u>45,214</u>	<u>14</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 57.89%

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 Apartment, Dementia 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 2,704

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: 12/31/11 Fiscal Year: 12/31/11
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	471,309	29,565	10,683	511,557		511,557		511,557			1
2	Food Purchase		388,986		388,986	(50,214)	338,772	(27,764)	311,008			2
3	Housekeeping	209,502	56,108		265,610		265,610		265,610			3
4	Laundry											4
5	Heat and Other Utilities			274,492	274,492		274,492	(13,161)	261,331			5
6	Maintenance	120,964	96,332	121,555	338,851		338,851		338,851			6
7	Other (specify):*											7
8	TOTAL General Services	801,775	570,991	406,730	1,779,496	(50,214)	1,729,282	(40,925)	1,688,357			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,714,777	107,007	2,515	1,824,299		1,824,299		1,824,299			10
10a	Therapy											10a
11	Activities	91,411	3,959	8,098	103,468		103,468		103,468			11
12	Social Services	45,004		12,216	57,220		57,220		57,220			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,851,192	110,966	26,429	1,988,587		1,988,587		1,988,587			16
	C. General Administration											
17	Administrative	113,761			113,761		113,761		113,761			17
18	Directors Fees											18
19	Professional Services			51,434	51,434		51,434	(10,467)	40,967			19
20	Dues, Fees, Subscriptions & Promotions			23,429	23,429		23,429	(633)	22,796			20
21	Clerical & General Office Expenses	219,575	24,841	142,098	386,514		386,514	(81,746)	304,768			21
22	Employee Benefits & Payroll Taxes			856,935	856,935	50,214	907,149		907,149			22
23	Inservice Training & Education											23
24	Travel and Seminar			26,518	26,518		26,518	(7,816)	18,702			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			96,732	96,732		96,732		96,732			26
27	Other (specify):*											27
28	TOTAL General Administration	333,336	24,841	1,197,146	1,555,323	50,214	1,605,537	(100,662)	1,504,875			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,986,303	706,798	1,630,305	5,323,406		5,323,406	(141,587)	5,181,819			29

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

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

Evenglow Lodge
Medicaid Cost Report
01/01/11 - 12/31/11

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>		13.90%
Evenglow Lodge Residents			
Census	45,214		
Meals Per Day	3		
Meals Served Per year	<u>135,642</u>	86.10%	
Total Meals Served	<u>157,542</u>	86.10%	13.90%
Food Cost			
Page 3 Line 2 Column 2	388,986		
Pre-Allocation Adjustments			
Meal Income - Page 5	(27,764)		
Food Cost For Allocation	361,222	361,222	361,222
Allocated Food Cost		<u>311,008</u>	<u>50,214</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			555,482	555,482		555,482		555,482			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,323	10,323		10,323	(10,323)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			565,805	565,805		565,805	(10,323)	555,482			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		100,535	380,374	480,909		480,909		480,909			39
40	Barber and Beauty Shops			432	432		432		432			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			102,641	102,641		102,641		102,641			42
43	Other (specify):*	866,958	139,054	617,177	1,623,189		1,623,189	(1,623,189)				43
44	TOTAL Special Cost Centers	866,958	239,589	1,100,624	2,207,171		2,207,171	(1,623,189)	583,982			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,853,261	946,387	3,296,734	8,096,382		8,096,382	(1,775,099)	6,321,283			45

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

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	(27,764)	02		4
5	Telephone, TV & Radio in Resident Rooms	(13,161)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,323)	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	(633)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(77,174)	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	(1,646,044)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,775,099)		\$	30

BHF USE ONLY							
48		49		50		51	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,775,099)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (4,572)	21	1
2	Development	(140,819)	43	2
3	Skyline Apartments	(81,272)	43	3
4	Evenglow Inn	(1,401,098)	43	4
5	Non-Allowable Seminar and Travel	(7,816)	24	5
6	Prior Period Legal Fees	(10,467)	19	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	(1,646,044)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	(27,764)	0	0	0	0	0	0	0	0	0	0	(27,764)	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	(13,161)	0	0	0	0	0	0	0	0	0	0	(13,161)	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	(40,925)	0	0	0	0	0	0	0	0	0	0	(40,925)	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	(10,467)	0	0	0	0	0	0	0	0	0	0	(10,467)	19
20	Fees, Subscriptions & Promotions	(633)	0	0	0	0	0	0	0	0	0	0	(633)	20
21	Clerical & General Office Expenses	(81,746)	0	0	0	0	0	0	0	0	0	0	(81,746)	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	(7,816)	0	0	0	0	0	0	0	0	0	0	(7,816)	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	(100,662)	0	0	0	0	0	0	0	0	0	0	(100,662)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(141,587)	0	0	0	0	0	0	0	0	0	0	(141,587)	29

Summary B

12/31/11

[illegible]

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Board of Trustees		Evenglow Inn	Pontiac, Illinois			
See Page 6 - Supplemental for Listing						

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

☐ YES ☒ NO

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

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

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	Ruth Bosman							1
2	Mary Ann Denker							2
3	Carol Flessner							3
4	Donovan Gardner							4
5	Dick Geschwind							5
6	Bert Kinate							6
7	Meri Knapp							7
8	Doug McCoy							8
9	Ray Owens							9
10	Jeanne Rapp							10
11	Wayne Taylor							11
12	John Taylor							12
13	Ed Vogelsinger							13
14	Gene Swartz							14
15	George Russell							15
16	Raydean Davis							16
17	Greg Besgrove							17
18	Leah Pogemiller							18
19	Virgil Sancken							19
20	Jime Wolfe							20
21								21
22	None of the Trustees listed above							22
23	received compensation from							23
24	Evenglow during 2011.							24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

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

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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.

	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

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	Berkadia Commerical		X	Mortgage	\$10,315.00	06/17/83	\$ 2,111,700	\$ 149,678	06/17/15	5.0000	\$ 10,323	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$10,315.00		\$ 2,111,700	\$ 149,678			\$ 10,323	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13	Interest Income		X								(10,323)	13
14	TOTAL Non-Facility Related						\$	\$			\$ (10,323)	14
15	TOTALS (line 9+line14)						\$ 2,111,700	\$ 149,678			\$	15

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

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

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

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 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 2011 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:		2006		8	
		2007		9	
		2008		10	
		2009		11	
		2010		12	
Non-Profit Entity - Not Subject To Real Estate Taxes				13	FROM R. E. TAX STATEMENT FOR 2010 \$ 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.

FACILITY NAME Evenglow Lodge COUNTY Livingston
FACILITY IDPH LICENSE NUMBER 0008425
CONTACT PERSON REGARDING THIS REPORT Jeremy M. Brune
TELEPHONE (779) 875 - 3979 FAX #: (866) 216 - 5355

Enter the tax index number and real estate tax assessed for 2010 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 2010.

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.)

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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.**

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 Inn - 26 Sheltered Care Beds (Separate IDPH License)

Skyline Apartments - 7 Independent Living Units on the 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

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	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			1966	528						12
13	Various			1971	402						13
14	Various			1972	210						14
15	Various			1973	345						15
16	Various			1974	1,865						16
17	Various			1977	5,000						17
18	Various			1978	6,309						18
19	Various			1979	2,839						19
20	Various			1980	10,103						20
21	Various			1981	1,760						21
22	Various			1982	11,306						22
23	Various			1984	48,725						23
24	Various			1985	37,039						24
25	Various			1986	58,125						25
26	Various			1987	9,819						26
27	Various			1988	6,792						27
28	Various			1989	57,731						28
29	Various			1990	129,555						29
30	Various			1991	83,379						30
31	Various			1992	77,791						31
32	Various			1993	106,402						32
33	Various			1994	12,511						33
34	Various			1995	433,474						34
35	Various			1996	223,735						35
36	Various			1997	131,074						36

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

See Page 12A, Line 70 for total

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

XI. OWNERSHIP COSTS (continued)

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

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	1998	\$ 133,503	\$		\$	\$	\$	37
38	Various	1999	17,677						38
39	Various	2000	128,114						39
40	Various	2001	13,178						40
41	Various	2002	38,379						41
42	Various	2003	29,683						42
43	Various	2004	35,991						43
44	Various	2005	161,286						44
45	Various	2006	100,203						45
46	Various	2007	103,683						46
47	Steam Line and Cell	2008	6,564						47
48	Hot Water Heater	2008	8,114						48
49	Window Blinds	2008	852						49
50	Carpet Front Office	2008	788						50
51	Toilets & Light Fixtures	2008	1,303						51
52	Credits on Shower Upgrades	2008	(2,114)						52
53	Shower Upgrades in Remodel	2008	4,200						53
54	Offsets For Ada Toilets in Remodels	2008	682						54
55	New Showers in Remodels	2008	12,808						55
56	New Showers in Remodels	2008	2,630						56
57	New Carpet in Remodels	2008	3,401						57
58	Replace Faucet in Dish Machine	2008	566						58
59	Carpeting	2008	1,249						59
60	Toilet for Remodel	2008	468						60
61	Pipes for New Toilets For Remodels	2008	459						61
62	Light Fixtures & Toilets for Remodels	2008	1,118						62
63	New Blinds for Remodels	2008	300						63
64	New Carpeting for Remodels	2008	1,325						64
65	New A/C Unit	2008	471						65
66	Landscaping	2008	1,391						66
67	Credit for New Toilet	2008	(156)						67
68	Pipes for New Showers	2008	3,390						68
69	New Showers and Installation	2008	5,220						69
70	TOTAL (lines 4 thru 69)		\$ 7,807,174	\$		\$	\$	\$	70

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

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	
1 Totals from Page 12A, Carried Forward		\$ 7,807,174	\$		\$	\$	\$	1
2 Carpeting in Remodel	2008	1,325						2
3 Carpet in Remodel	2008	828						3
4 New Cabinets in Remodel	2008	5,100						4
5 Blinds in Remodel	2008	568						5
6 Lighting for Crosses	2008	4,498						6
7 Repeaters for Call System	2008	1,100						7
8 Carpet	2008	544						8
9 Garage Additions	2008	78,885						9
10 Sink and Faucet in Dining Room	2008	930						10
11 Toilets	2008	1,040						11
12 Carpet	2008	544						12
13 Asbestos Abatement for Boiler Replacement	2008	22,400						13
14 Kitchenette Cabinet in Remodels	2008	2,550						14
15 Closet Doors	2008	126						15
16 Lighting for Crosses	2008	4,498						16
17 Carpeting for Room Remodels	2008	2,143						17
18 Window Blinds	2008	575						18
19 New Pipes for Ada Toilets	2008	677						19
20 Plumbing For New Showers	2008	6,930						20
21 New Showers in Remodel	2008	13,019						21
22 Chapel HVAC Project	2008	1,628						22
23 Carpet in Remodel	2008	519						23
24 Pneumatic Valve	2008	704						24
25 1st Floor Kitchenette Countertop	2008	1,034						25
26 HC Roof Replacement	2008	4,174						26
27 Faucet 1st Floor Kitchen	2008	60						27
28 Engineer For Roof Project	2008	2,700						28
29 HVAC & Energy Savings Project	2008	446,099						29
30 Electrical Outlet Strips	2008	1,334						30
31 Roof Project	2008	97,118						31
32 Engineering & Plans for Room Remodeling	2009	2,925						32
33 Crash Bar on Door	2009	3,063						33
34 TOTAL (lines 1 thru 33)		\$ 8,516,812	\$		\$	\$	\$	34

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

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/11

Ending:

12/31/11

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	
1 Totals from Page 12B, Carried Forward		\$ 8,516,812	\$		\$	\$	\$	1
2 Sprinkler System in Elevator Shafts	2009	22,474						2
3 Engineering for Fire Panel Upgrade	2009	13,000						3
4 Fire Panel / Dialer For Fire Panel	2009	21,492						4
5 Carpeting	2009	3,094						5
6 Time Clock System	2009	16,679						6
7 Apt Remodels - Carpet / Showers / Doors / Lighting / Toilets	2009	24,084						7
8 HVAC & Energy Savings Project	2009	892,198						8
9 Roof Project	2009	179,383						9
10 Piping for New Ventilator	2009	3,937						10
11 New Shower / Plumbing	2009	16,056						11
12 Carpeting	2009	6,599						12
13 New Toilets / Pipes / Shower Plumbing	2009	4,033						13
14 Electrical Repairs	2009	7,070						14
15 Exterior Lighting	2010	3,418						15
16 Health Center (Carpeting, Wall Paper, Flooring, Win. Trt).	2010	202,395						16
17 NAC Panels for Fire System	2010	2,880						17
18 Boiler Room Valve	2010	3,558						18
19 Carpeting	2010	1,478						19
20 Plumbing for Shower in Remodel	2010	2,437						20
21 Lodge Redorating (Carpet, Window Treatments, Flooring)	2010	50,077						21
22 Plumbing and Shower Installation	2010	12,964						22
23 Wallpaper	2010	542						23
24 Carpeting	2010	2,341						24
25 Carpeting	2010	1,348						25
26 Lighting	2010	4,186						26
27 Carpeting	2010	540						27
28 Window Replacement Project	2010	359,050						28
29 Repeater for Ariel Call System	2011	550						29
30 Feed Pump for Boiler	2011	1,345						30
31 New Shower for 601	2011	1,147						31
32 New Shower for 601	2011	2,544						32
33 Carpeting for 601	2011	802						33
34 TOTAL (lines 1 thru 33)		\$ 10,380,513	\$		\$	\$	\$	34

**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 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 12C, Carried Forward		\$ 10,380,513	\$		\$	\$	\$	1
2	New Shower for 322	2011	2,630						2
3	New Shower for 322	2011	1,120						3
4	Pump Motor for Pressure Pumps	2011	903						4
5	New Showers for 306 & 422	2011	2,067						5
6	New Showers for 306 & 422	2011	5,259						6
7	Door Closer for Kitchen	2011	520						7
8	Carpeting for 322	2011	1,371						8
9	Carpeting for 422	2011	1,477						9
10	New Shower for 622	2011	2,630						10
11	New Shower for 622	2011	798						11
12	Carpeting for 622	2011	1,477						12
13	Fire System Check Valve	2011	1,530						13
14	New Boiler - From CIP In PY	2011	20,000						14
15	New Boiler	2011	24,367						15
16	Boiler Header Including Insulation	2011	14,388						16
17	Replace Resin in Water Softner	2011	7,518						17
18									18
19	Financial Statement Depreciation			515,454		515,454		7,018,391	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	TOTAL (lines 1 thru 33)		\$ 10,468,566	\$ 515,454		\$ 515,454	\$	\$ 7,018,391	34

**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	\$2,120,449	\$33,407	\$33,407	\$	5 - 15	\$1,606,035	71
72	Current Year Purchases	46,348	3,332	3,332		5 - 15	3,332	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$2,166,797	\$36,739	\$36,739	\$		\$1,609,367	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	Van & Mini-Van	Ford - 1986 / Dodge 2001	1986 / 2001	\$59,523	\$	\$	\$	4 - 5	\$59,523	76
77	Trucks / Bus	Various	2001 / 2004	47,025				5	47,025	77
78	Pick-Up Truck	Various	2009	9,231	1,319	1,319		7	3,187	78
79	Van / Tractor	Various	2010	12,200	1,970	1,970		4 - 10	2,986	79
80	TOTALS			\$127,979	\$3,289	\$3,289	\$		\$112,721	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)	\$12,840,37281
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$555,48282
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$555,48283
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$8,740,47985

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 Apartments (Line 43)	\$420,136	\$16,363	\$306,400	86
87	Evenglow Inn (Line 43)	3,846,236	107,557	1,195,311	87
88					88
89					89
90					90
91	TOTALS	\$4,266,372	\$123,920	\$1,501,711	91

G. Construction-in-Progress

	Description	Cost	
92	Lobby and Canopy Renov.	\$328,234	92
93			93
94			94
95		\$328,234	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6					0			6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .
9. Option to Buy: YES NO Terms: *

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

15. Is Movable equipment rental included in building rental? YES NO
16. Rental Amount for movable equipment: \$ 0 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

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year EndingAnnual Rent
12. /2012 \$
13. /2013 \$
14. /2014 \$

* 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.

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
		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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist		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 prescripts				49,475		49,475	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					51,060		51,060	12
13	Other (specify): See Supplemental	39 - 03				380,374			380,374	13
14	TOTAL			\$		\$ 380,374	\$ 100,535		\$ 480,909	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.

Evenglow Lodge
Medicaid Cost Report
01/01/11 - 12/31/11

Page 16 Supplemental Schedule

Description	Supplies	Other
Medical Supplies	50,812	
Therapy Supplies	248	
Therapy (PT, OT, and ST)		360,980
Lab and Other Services		19,394
Total	51,060	380,374

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,873,347	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 174,732)	1,192,543		3
4	Supply Inventory (priced at Cost)	47,501		4
5	Short-Term Investments	2,074,892		5
6	Prepaid Insurance	149,673		6
7	Other Prepaid Expenses	34,417		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	164,900		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,537,273	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	82,465		12
13	Land	983,584		13
14	Buildings, at Historical Cost	14,859,188		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,145,627		16
17	Accumulated Depreciation (book methods)	(10,242,189)		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	360,564		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 8,189,239	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 14,726,512	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 550,475	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	65,215		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	270,855		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,981		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	9,896		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	160,425		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,077,847	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,335,423		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,335,423	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,413,270	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 12,313,243	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 14,726,513	\$	48

*(See instructions.)

Evenglow Lodge
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Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Interest and Dividend Receivable	5,055	
Contributions Receivable	159,845	
Total	164,900	-
Line 23 - Other Long Term Assets		
Construction In Progress	328,234	
Deferred Financing Costs - Net of Amortization	32,330	
Total	360,564	-
Line 36 - Other Current Liabilities		
Deferred Support - Skyline Apartments	159,402	
Deferred Support - Founders Gifts	1,023	
Total	160,425	-

Line 43 - Other Long Term Liabilities

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 11,802,906	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 11,802,906	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	510,337	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)	\$ 510,337	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)	\$ 12,313,243	24 *

* This must agree with page 17, line 47.

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			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,293,335	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,293,335	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		13
14	Non-Patient Meals	27,764	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	16,095	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)	\$ 43,859	23
	D. Non-Operating Revenue		
24	Contributions	343,389	24
25	Interest and Other Investment Income***	245,410	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 588,799	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,680,726	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,680,726	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,606,719	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,779,496	31
32	Health Care	1,988,587	32
33	General Administration	1,555,323	33
	B. Capital Expense		
34	Ownership	565,805	34
	C. Ancillary Expense		
35	Special Cost Centers	2,104,530	35
36	Provider Participation Fee	102,641	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,096,382	40
41	Income before Income Taxes (line 30 minus line 40)**	510,337	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 510,337	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes 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.

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Page 19 Supplemental Schedule

[illegible]

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	1,945	2,160	\$ 71,887	\$ 33.28	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,214	13,732	339,155	24.70	3
4	Licensed Practical Nurses	17,761	19,853	436,591	21.99	4
5	CNAs & Orderlies	66,597	73,753	848,463	11.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,953	8,690	91,411	10.52	10
11	Social Service Workers	3,671	3,886	45,004	11.58	11
12	Dietician					12
13	Food Service Supervisor	2,433	2,653	48,107	18.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	37,119	42,453	423,202	9.97	15
16	Dishwashers					16
17	Maintenance Workers	7,516	8,416	120,964	14.37	17
18	Housekeepers	20,291	22,202	209,502	9.44	18
19	Laundry					19
20	Administrator	1,955	2,087	113,761	54.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,579	15,918	219,575	13.79	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	1,561	1,725	18,681	10.83	31
32	Other Health Care(specify)					32
33	Other(specify) Supplemental	56,115	62,481	866,958	13.88	33
34	TOTAL (lines 1 - 33)	251,710	280,009	\$ 3,853,261 *	\$ 13.76	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 10,683	01 - 03	35
36	Medical Director		3,600	09 - 03	36
37	Medical Records Consultant		2,515	10 - 03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		8,098	11 - 03	44
45	Social Service Consultant		12,216	12 - 03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 37,112		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

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Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Development and Marketing	4,834	5,746	103,027
Skyline Inn	1,161	1,288	19,461
Evenglow Inn	50,120	55,447	744,470
Total	56,115	62,481	866,958

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
Mark Hovren	Administrator	0	\$ 113,761	Workers' Compensation Insurance		\$ 139,451	IDPH License Fee		\$		
				Unemployment Compensation Insurance		5,681	Advertising: Employee Recruitment		2,665		
				FICA Taxes		228,585	Health Care Worker Background Check				
				Employee Health Insurance		403,252	(Indicate # of checks performed)				
				Employee Meals		50,214	Patient Background Checks				
				Illinois Municipal Retirement Fund (IMRF)*			Subscriptions		2,631		
				Pre-Employment Physicals		13,168	Licenses and Dues		17,501		
				Employee Retention		10,919					
				Pension		55,879					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)											
B. Administrative - Other							Less: Public Relations Expense		()		
Description			Amount				Non-allowable advertising		()		
			\$				Yellow page advertising		()		
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)		\$ 907,149	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 22,796		
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		
Westervelt, Johnson,			\$			\$	Out-of-State Travel		\$		
Nicoll & Keller, LLC	Legal		33,976								
Polsinelli Shughart	Legal		613								
Jeremy Brune & Assoc. LLC	Accounting / Auditing		18,471				In-State Travel				
Other Professional Services	Other Professional Services		2,191								
Allocated - Evenglow Inn	Professional Fees - Ln 43		(801)				Seminar Expense		32,148		
Allocated - Skyline Apartments	Professional Fees - Ln 43		(3,016)				Line 42 - Development Expense		(5,630)		
Pg. 5 Adjustment - Prior Period	Legal Fees		(10,467)				Additional Page 5 Adjustment		(7,816)		
							Entertainment Expense		()		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 40,967	TOTAL		\$	(agree to Sch. V, line 24, col. 8)		\$ 18,702		

*** Attach copy of IMRF notifications**

****See instructions.**

Eveningstar Lodge

[illegible]

Consolidated to Line 43 (5,632) (5,632)

Additional Page & Adjustments	(7/2016)	(7/2016)

Ending Balance	14,702	18,302	-
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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	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

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. LSN / AAHSA - \$6,210
- (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. \$ 37,320 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. \$ 102,641
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 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 benefit: on Schedule V. \$ 50,214 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 27,764
- (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: 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) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees