

		FOR BHF USE					

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

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>01/01/20</u> to <u>12/31/20</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: _____			
Date of Initial License for Current Owners: <u>03/06/57</u>			
Type of Ownership:			
☒ VOLUNTARY, NON-PROFIT			
☒ Charitable Corp.			
☐ Trust			
IRS Exemption Code <u>501(c)(3)</u>			
☐ PROPRIETARY			
☐ Individual			
☐ Partnership			
☐ Corporation			
☐ "Sub-S" Corp.			
☐ Limited Liability Co.			
☐ Trust			
☐ Other _____			
☐ GOVERNMENTAL			
☐ State			
☐ County			
☐ Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>Jeremy M. Brune, CPA</u>			
Telephone Number: <u>(779) 875 - 3979</u>			
Email Address: _____			
		Officer or Administrator of Provider	
		(Signed) _____ (Date) _____	
		(Type or Print Name) _____	
		(Title) _____	
		(Signed) _____ (Date) _____	
		Paid Preparer	
		(Print Name and Title) <u>Jeremy M. Brune, CPA</u> <u>Chief Executive Officer</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>	
		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA					
A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds <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>26,718</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>51,606</u>	5
6		ICF/DD 16 or Less			6
7	<u>214</u>	TOTALS	<u>214</u>	<u>78,324</u>	7

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					8
9	SNF/PED	<u>3,467</u>	<u>9,678</u>	<u>3,139</u>	<u>16,284</u>	9
10	ICF					10
11	ICF/DD					11
12	SC		<u>21,643</u>		<u>21,643</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>3,467</u>	<u>31,321</u>	<u>3,139</u>	<u>37,927</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 48.42%

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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

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

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 73 and days of care provided 2,561

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐

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

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	629,321	27,105	13,195	669,621		669,621		669,621			1
2	Food Purchase		290,764		290,764	(46,932)	243,832	(1,100)	242,732			2
3	Housekeeping	249,925	62,739		312,664		312,664		312,664			3
4	Laundry											4
5	Heat and Other Utilities			250,852	250,852		250,852	(22,047)	228,805			5
6	Maintenance	107,735	83,335	112,894	303,964		303,964		303,964			6
7	Other (specify):* See Supplemental											7
8	TOTAL General Services	986,981	463,942	376,941	1,827,864	(46,932)	1,780,932	(23,147)	1,757,785			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	2,248,740	188,914	225,759	2,663,414		2,663,414	(12,801)	2,650,613			10
10a	Therapy			2,202	2,202		2,202		2,202			10a
11	Activities	108,311	4,000	783	113,094		113,094		113,094			11
12	Social Services	48,480		24,172	72,652		72,652		72,652			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* See Supplemental											15
16	TOTAL Health Care and Programs	2,405,531	192,915	261,917	2,860,362		2,860,362	(12,801)	2,847,561			16
	C. General Administration											
17	Administrative	131,312			131,312		131,312		131,312			17
18	Directors Fees											18
19	Professional Services			26,680	26,680		26,680	(4,576)	22,104			19
20	Dues, Fees, Subscriptions & Promotions			48,540	48,540		48,540		48,540			20
21	Clerical & General Office Expenses	357,114	33,956	451,512	842,581		842,581	(253,589)	588,992			21
22	Employee Benefits & Payroll Taxes			1,328,268	1,328,268	46,932	1,375,200	(53,699)	1,321,501			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,396	2,396		2,396		2,396			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			171,742	171,742		171,742		171,742			26
27	Other (specify):* See Supplemental											27
28	TOTAL General Administration	488,426	33,956	2,029,138	2,551,519	46,932	2,598,451	(311,864)	2,286,587			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,880,938	690,813	2,667,995	7,239,746		7,239,746	(347,812)	6,891,934			29

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

SEE ACCOUNTANTS' PREPARATION REPORT

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

Evenglow Lodge
Medicaid Cost Report
01/01/20 - 12/31/20

Page 3 Supplemental Schedule - Reclassification Detail

Description	Census Days	Employees	Factor	Meals Served	% of Food Cost	Allowable Food	Resident Portion	Employee Portion
Resident Meals								
Resident Census	37,927		3.00	113,781	83.86%	290,764	243,832	
Employee Meals								
Employees		60	365.00	21,900	16.14%	290,764		46,932
Total				135,681	100.00%		243,832	46,932

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			769,697	769,697		769,697	(18,783)	750,914			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,224	15,224		15,224		15,224			35
36	Other (specify):* See Supplemental											36
37	TOTAL Ownership			784,921	784,921		784,921	(18,783)	766,138			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		129,104	434,591	563,695		563,695		563,695			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			123,402	123,402		123,402		123,402			42
43	Other (specify):* See Supplemental	1,209,947	145,323	742,246	2,097,516		2,097,516		2,097,516			43
44	TOTAL Special Cost Centers	1,209,947	274,427	1,300,239	2,784,613		2,784,613		2,784,613			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,090,885	965,240	4,753,156	10,809,280		10,809,280	(366,595)	10,442,685			45

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

SEE ACCOUNTANTS' PREPARATION REPORT

Page 4 Supplemental Schedule

Description	Salaries		Supplies		Other		Total	
Line 36 - Other Capital Costs								
								-
								-
								-
								-
								-
								-
Sub-Total		-		-		-		-
Line 43 - Other Special Cost Centers								
Skyline Apartments		24,520		2,192		82,835		109,547
Evenglow Inn		1,092,810		143,131		330,671		1,566,612
Development		92,617				90,910		183,527
Investments						31,338		31,338
Other						206,492		206,492
								-
Sub-Total		1,209,947		145,323		742,246		2,097,516

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	(1,100)	02		4
5	Telephone, TV & Radio in Resident Rooms	(22,047)	05		5
6	Rented Facility Space	(18,783)	30		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,489)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(237,540)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental Schedule	(74,636)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (366,595)		\$	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))	\$ (366,595)		37

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income - Tax Credits	\$ (53,699)	22	1
2	Miscellaneous Income - Other	(3,560)	21	2
3	Professional Fees - Legal	(1,437)	19	3
4	Professional Fees - Other	(3,139)	19	4
5	HFS Grant Sub-Award	(12,801)	10	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(74,636)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evenglow Lodge# 0008425

Report Period Beginning:

01/01/20

Ending:

12/31/20

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,100)	0	0	0	0	0	0	0	0	0	0	(1,100)	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	(22,047)	0	0	0	0	0	0	0	0	0	0	(22,047)	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	(23,147)	0	0	0	0	0	0	0	0	0	0	(23,147)	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	(12,801)	0	0	0	0	0	0	0	0	0	0	(12,801)	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	(12,801)	0	0	0	0	0	0	0	0	0	0	(12,801)	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	(4,576)	0	0	0	0	0	0	0	0	0	0	(4,576)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(253,589)	0	0	0	0	0	0	0	0	0	0	(253,589)	21
22	Employee Benefits & Payroll Taxes	(53,699)	0	0	0	0	0	0	0	0	0	0	(53,699)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	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	(311,864)	0	0	0	0	0	0	0	0	0	0	(311,864)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(347,812)	0	0	0	0	0	0	0	0	0	0	(347,812)	29

STATE OF ILLINOIS

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	(18,783)	0	0	0	0	0	0	0	0	0	0	(18,783)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	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	(18,783)	0	0	0	0	0	0	0	0	0	0	(18,783)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(366,595)	0	0	0	0	0	0	0	0	0	0	(366,595)	45

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.

1OWNERS		2RELATED NURSING HOMES		3OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Board of Trustees		Evenglow Inn	Pontiac, Illinois			

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.

YESNO

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.

1Schedule V		2Line	3Cost Per General LedgerItem	4Amount	5Cost to Related OrganizationName of Related Organization	6Percent of Ownership	7Operating Cost of Related Organization	8 Difference: 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.

SEE ACCOUNTANTS' PREPARATION REPORT

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	Mary Denker							3
4	Rev. James Barnett							4
5	Carol Flessner							5
6	Richard Geschwind							6
7	MaLinda Hillman							7
8	John Trewartha							8
9	Sharon Arnold							9
10	Robert Walter							10
11	Douglas McCoy							11
12	Jeanne Rapp							12
13	Wayne Taylor							13
14	John Taylor							14
15	Roger Wahls							15
16	Alberta Kinate							16
17	Tom Corcoran							17
18	Rev. Paul Arnold							18
19								19
20								20
21	None of the above listed Trustees							21
22	received compensation directory or							22
23	indirectly during 2020.							23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' PREPARATION 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									\$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ 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' PREPARATION 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	N/A											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$				\$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	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. \$ _____ Line # _____

* 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.)

SEE ACCOUNTANTS' PREPARATION REPORT

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 2019 report.			\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$		2
3. Under or (over) accrual (line 2 minus line 1).			\$		3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015		8	
		2016		9	
		2017		10	
		2018		11	
		2019		12	
N/A - Evenglow Lodge is not subject to real estate taxes.					

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

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' PREPARATION REPORT

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

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

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.)

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 Steel 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 (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' PREPARATION REPORT

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			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' PREPARATION REPORT

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	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	Various	2011	48,181						48
49	Various	2012	384,634						49
50	Various	2013	387,335						50
51	Various	2014	1,648,209						51
52	Various	2015	97,543						52
53	Various	2016	624,818						53
54	Shower Installations (Room 204, 216, 304, 404 & 409)	2017	18,041						54
55	Carpeting (Rooms 215, 320, 321, 417, 418, 606, 612 and ADON)	2017	6,041						55
56	AC Unit - Kitchen including Fending for Outside Unit	2017	104,526						56
57	Boiler - Evaluation, Side Stream Unit, and Coil Replacement	2017	81,151						57
58	Flooring and Drapery - Dining Room	2017	40,285						58
59	Crash Bards, Doors, and Fire Holders	2017	11,684						59
60	Carpet (Chapel, 202, 415, 622, 4th & 5th Floor Hallway	2018	35,650						60
61	Docking Station (Exterior next to Generator)	2018	46,636						61
62	Electrical Outlets (All resident rooms)	2018	4,272						62
63	Electrical Panel Upgrade	2018	6,197						63
64	Fire Doors	2018	6,873						64
65	Gardner Room (Paint, Electrical, Ceiling Tile, Plumbing, Etc.)	2018	37,325						65
66	Shower Conversion (Rms. 208, 504, 606)	2018	12,284						66
67	Sidewalk Replacement (Exterior next to generator)	2018	11,131						67
68	Steam Trap	2018	3,348						68
69	Carpet (6th Floor Planks & Rooms 610, 611, and 409)	2019	13,783						69
70	TOTAL (lines 4 thru 69)		\$ 13,298,124	\$		\$	\$	\$	70

SEE ACCOUNTANTS' PREPARATION 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	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		\$ 13,298,124	\$		\$	\$	\$	1
2 Steam Coil	2019	7,797						2
3 Water Heater Replacement	2019	11,608						3
4 Generator Breaker Switch	2019	33,600						4
5 Loading Dock Concrete Pad, Lock, and Key	2019	87,157						5
6 Fuel Tank	2019	29,060						6
7 Carpeting (Rooms 215 - 218, 412 - 414)	2020	4,711						7
8 Door (Holders, Levers, Locks & Keys)	2020	3,043						8
9 Water Heater	2020	11,608						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 Depreciation			631,455		631,455		11,087,801	32
33								33
34 TOTAL (lines 1 thru 33)		\$ 13,486,707	\$ 631,455		\$ 631,455	\$	\$ 11,087,801	34

SEE ACCOUNTANTS' PREPARATION 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	\$2,404,824	\$	\$	\$		\$	71
72	Current Year Purchases	59,663						72
73	Fully Depreciated Assets							73
74	Depreciation		105,333	105,333			1,521,906	74
75	TOTALS	\$2,464,487	\$105,333	\$105,333	\$		\$1,521,906	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 / 2016	\$56,130	\$6,174	\$6,174	\$		\$12,009	76
77	Facility	Bus and Hitch	2001 / 2019	64,487	7,717	7,717			52,272	77
78	Facility	Pick - Up Truck	2009	9,231					9,231	78
79	Facility	Van / Tractor	2010	4,700	235	235			4,700	79
80	TOTALS			\$134,548	\$14,126	\$14,126	\$		\$78,212	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$16,162,772	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$750,914	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$750,914	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$12,687,919	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 Apartments	\$445,680	\$21,477	\$372,172	86
87	Evenglow Inn	5,045,993	128,821	2,209,314	87
88	303 E. Madison Street	20,000			88
89	304 E. Madison Street	236,927	4,338	4,338	89
90	308 E. Madison Street	62,077	7,220		90
91	TOTALS	\$5,810,677	\$161,856	\$2,585,824	91

G. Construction-in-Progress

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

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

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

SEE ACCOUNTANTS' PREPARATION 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?
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								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: \$ 15,224 Description: See Supplemental Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Description		Amount		Total
Building Rental				
				-
N/A				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		-	-	
Equipment Rental				
Ecolab - Dishwahr		4,091		4,091
Wells Fargo - Copiers		11,133		11,133
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
				-
Total		15,224	15,224	

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.
SEE ACCOUNTANTS' PREPARATION REPORT

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 198,599	\$		\$ 198,599	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,901			9,901	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			178,255			178,255	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				104,936		104,936	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): See Supplemental	39 - 02					24,168		24,168	12
13	Other (specify): See Supplemental	39 - 03				47,836			47,836	13
14	TOTAL			\$		\$ 434,591	\$ 129,104		\$ 563,695	14

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

SEE ACCOUNTANTS' PREPARATION REPORT

Evenglow Lodge
Medicaid Cost Report
01/01/20 - 12/31/20

Page 16 Supplemental Schedule

[illegible]

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,798,317	\$	1
2	Cash-Patient Deposits	5,865		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 325,000)	855,932		3
4	Supply Inventory (priced at Cost (FIFO))	74,967		4
5	Short-Term Investments			5
6	Prepaid Insurance	101,865		6
7	Other Prepaid Expenses	162,961		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental	213,642		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,213,549	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,142,158		12
13	Land	1,417,647		13
14	Buildings, at Historical Cost	18,106,524		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,327,050		16
17	Accumulated Depreciation (book methods)	(15,273,744)		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	6,661,972		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 21,381,607	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 25,595,156	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 594,350	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,865		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	345,765		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,319		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,699		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental	1,385,829		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,376,826	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,376,826	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 23,218,329	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 25,595,156	\$	48

SEE ACCOUNTANTS' PREPARATION REPORT

*(See instructions.)

Description		Operating		Building		Total
Line 9 - Other Current Assets						
Accrued Interest & Dividends		38,864				38,864
Estates Receivable		174,778				174,778
						-
						-
						-
Sub-Total		213,642		-		213,642
Line 23 - Long Term Assets						
Beneficial Interest in Perpetual Trust		4,936,772				4,936,772
Construction in Progress		1,629,949				1,629,949
Assets Limited To Use		95,251				95,251
						-
						-
Sub-Total		6,661,972		-		6,661,972
Line 36 - Other Current Liability						
Charitable Gift Payable		21,108				21,108
Deferred Revenue Entrance Payable		25,071				25,071
Refundable Entrance Fee Liability		195,750				195,750
PPP Loan (Deferred Support)		1,143,900				1,143,900
						-
Sub-Total		1,385,829		-		1,385,829
Line 43 - Long term Liabilities						
						-
						-
						-
						-
						-
Sub-Total		-		-		-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 23,096,640	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 23,096,640	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	121,690	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)	\$ 121,690	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)	\$ 23,218,329	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning: 01/01/20

Ending:

12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,074,866	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,074,866	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	642,767	10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	4,998	13
14	Non-Patient Meals	1,100	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	18,783	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)	\$ 667,648	23
	D. Non-Operating Revenue		
24	Contributions	353,413	24
25	Interest and Other Investment Income***	761,341	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,114,754	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental</u>	2,073,703	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,073,703	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,930,970	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,827,864	31
32	Health Care	2,860,362	32
33	General Administration	2,551,519	33
	B. Capital Expense		
34	Ownership	784,921	34
	C. Ancillary Expense		
35	Special Cost Centers	2,661,211	35
36	Provider Participation Fee	123,402	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,809,280	40
41	Income before Income Taxes (line 30 minus line 40)**	121,690	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 121,690	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 548,705	44
45	Private Pay - Net Inpatient Revenue	4,984,426	45
46	Medicare - Net Inpatient Revenue	1,541,735	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,074,866	49

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

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

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

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

SEE ACCOUNTANTS' PREPARATION REPORT

Evenglow Lodge
Medicaid Cost Report
01/01/20 - 12/31/20

Page 19 Supplemental Schedule

Description		Amount	Total
Evenglow Inn		1,845,178	1,845,178
Skyline Apartments		171,266	171,266
Sick and Family Leave Tax Credits		53,699	53,699
Miscellaneous Income		3,560	3,560
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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	2,007	2,199	\$ 98,348	\$ 44.72	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,585	12,814	404,462	31.56	3
4	Licensed Practical Nurses	16,877	18,532	501,217	27.05	4
5	CNAs & Orderlies	57,981	64,576	1,042,696	16.15	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,052	2,208	37,454	16.96	9
10	Activity Assistants	5,120	5,513	70,857	12.85	10
11	Social Service Workers	1,863	2,252	48,480	21.53	11
12	Dietician					12
13	Food Service Supervisor	1,948	2,160	56,991	26.38	13
14	Head Cook					14
15	Cook Helpers/Assistants	41,928	46,259	572,331	12.37	15
16	Dishwashers					16
17	Maintenance Workers	5,159	5,640	107,735	19.10	17
18	Housekeepers	19,076	21,145	249,925	11.82	18
19	Laundry					19
20	Administrator	1,543	1,769	131,312	74.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,208	15,642	323,117	20.66	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					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	65,336	74,998	1,445,960	19.28	33
34	TOTAL (lines 1 - 33)	246,683	275,707	\$ 5,090,885 *	\$ 18.46	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		\$ 7,982	01 - 03	35
36	Medical Director		9,000	09 - 03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		10,414	10 - 03	39
40	Physical Therapy Consultant		2,202	10a - 03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		3,224	12 - 03	45
46	Other(specify) See Supplemental		236,294		46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 269,116		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' PREPARATION REPORT

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

** See instructions.

Evenglow Lodge
Medicaid Cost Report
01/01/20 - 12/31/20

Page 20 Supplemental Schedule

Description	CC Reference	Hours Worked	Hours Paid	Salary	Average Rate	Hours Paid	Contracted Cost
Nursing Home Employees							
RN with Admin Duties	10	2,033	2,298	80,439	35.00		
LPN with Admin Duties	10	2,030	2,295	76,077	33.15		
Resident Support	10	3,152	3,379	45,500	13.47		
Admissions Coordinator	21	1,934	2,121	33,997	16.03		
Evenglow Inn	43	52,370	60,509	1,092,810	18.06		
Skyline Apartments	43	931	1,025	24,520	23.92		
Development	43	2,886	3,371	92,617	27.47		
					-		
					-		
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					-		
Total		65,336	74,998	1,445,960	19.28		

Contracted Services

Agency Nursing	10			215,345
Pastoral Care	12			20,949
Total			-	236,294

STATE OF ILLINOIS

Facility Name & ID NumberEvenglow Lodge# 0008425Report Period Beginning:01/01/20Ending:12/31/20Page 21

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Hovren	President	0	\$ 131,312
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 131,312

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Polsinelli Shughart, PC	Legal	\$ 3,008
Kopon Airdo, LLC	Legal	181
Jeremy Brune & Assoc., LLC	Audit, Tax, & Cost Reports	20,352
Other	Non-Allowable	3,139
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 26,680

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 167,507
Unemployment Compensation Insurance	
FICA Taxes	364,569
Employee Health Insurance	659,224
Employee Meals	46,932
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Contributions	90,538
Other	46,430
Sick and Family Leave Tax Credits	(53,699)
TOTAL (agree to Schedule V, line 22, col.8)	

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

Description	Line #	Amount
		\$
TOTAL		\$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	\$ 1,990
Advertising: Employee Recruitment	13,674
Health Care Worker Background Check (Indicate # of checks performed)	
Patient Background Checks	
Dues - Leading Age	7,472
Dues and Subscriptions	25,404
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	2,396
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 2,396

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' PREPARATION REPORT

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

Evenglow Lodge
Medicaid Cost Report
01/01/20 - 12/31/20

Page 21 Supplemental Schedule - Legal Invoice Detail

Vendor	Service Description (Allowable)	Invoice Date		Amount	Non-Allowable	Allowable
Kopon Airdo, LLC	Resident / Public Health Matters	01/31/20		181		181
Polsinelli Shughart, PC	Resident / Public Health Matters	01/31/20		628		628
Polsinelli Shughart, PC	Resident / Public Health Matters	03/31/20		262		262
Polsinelli Shughart, PC		04/30/20		658	658	-
Polsinelli Shughart, PC		05/31/20		566	566	-
Polsinelli Shughart, PC	Resident / Public Health Matters	07/31/20		251	160	91
Polsinelli Shughart, PC	Audit Response Letter	08/31/20		296		296
Polsinelli Shughart, PC	Audit Response Letter	08/31/20		238		238
Polsinelli Shughart, PC	Resident / Public Health Matters	09/30/20		109	54	56
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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 - \$7,472

(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.

\$

Line

10 - 02

(7)Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.

(8)Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A

(9)Are you presently operating under a sublease agreement?

YES

X

NO

(10)Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

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

\$

123,402

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?

See Pg. 2 Q. E

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15)Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

46,932

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$

1,100

(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 (Not Final)

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

Yes

(19)Has a schedule for the legal fees reported on the cost report been provided by the facility?

Yes

See page 39 of the instructions for details.

Attach invoices and a summary of services for all architect and appraisal fees.
- SEE ACCOUNTANTS' PREPARATION REPORT
- HFS 3745 (N-4-99)
- IL478-2471