

		FOR BHF USE					

LL1

2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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

I. IDPH License ID Number: 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:

X

VOLUNTARY,NON-PROFIT

X

Charitable Corp.

Trust

IRS Exemption Code 501(c)(3)

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:
Name: Larry Templin Telephone Number: (630) 361-2868
Email Address:

SEE ACCOUNTANTS' PREPARATION REPORT

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2025 to 12/31/2025 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)

(Title)

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title) Larry Templin Partner

(Firm Name & Address) Templin Healthcare Accounting Services, LLP P.O. Box 326, Plainfield, IL 60544-0326

(Telephone) (630) 361-2868 Fax # ()

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 1/1/2025 Ending: 12/31/2025

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>48</u>	Skilled (SNF)	<u>48</u>	<u>17,520</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>141</u>	Sheltered Care (SC)	<u>141</u>	<u>51,465</u>	5
6		ICF/DD 16 or Less			6
7	<u>189</u>	TOTALS	<u>189</u>	<u>68,985</u>	7

B. Census-For the entire report period.										
	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF						1,010	275	1,285	8
9	SNF/PED									9
10	ICF	1,254	2,037			5,326			8,617	10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	1,254	2,037			5,326	1,010	275	9,902	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 14.35%

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)
None

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 ☒ Non-allowable costs have been eliminated in Schedule V, Column 7

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 3/6/57

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 certified beds.
number of certified beds 48

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS
MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/25 Fiscal Year: 12/31/25
* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number

Evenglow Lodge

0008425

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

Page 3

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	416,204	245	32,102	448,551		448,551		448,551			1
2	Food Purchase		154,831		154,831		154,831	(20)	154,811			2
3	Housekeeping	121,774	20,613		142,387		142,387		142,387			3
4	Laundry											4
5	Heat and Other Utilities			267,309	267,309		267,309		267,309			5
6	Maintenance	64,531	44,292	135,958	244,781		244,781	(5,484)	239,297			6
7	Other (specify):*											7
8	TOTAL General Services	602,509	219,981	435,369	1,257,859		1,257,859	(5,504)	1,252,355			8
	B. Health Care and Programs											
9	Medical Director			19,500	19,500		19,500		19,500			9
10	Nursing and Medical Records	1,478,813	116,163	195,276	1,790,252		1,790,252		1,790,252			10
10a	Therapy											10a
11	Activities	31,986	3,668		35,654		35,654		35,654			11
12	Social Services	74,390	296	15,478	90,164		90,164		90,164			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,585,189	120,127	230,254	1,935,570		1,935,570		1,935,570			16
	C. General Administration											
17	Administrative	72,180			72,180		72,180		72,180			17
18	Directors Fees											18
19	Professional Services			129,067	129,067		129,067		129,067			19
20	Dues, Fees, Subscriptions & Promotions			16,414	16,414		16,414	(379)	16,035			20
21	Clerical & General Office Expenses	155,460	5,015	35,840	196,315		196,315	(75)	196,240			21
22	Employee Benefits & Payroll Taxes			1,399,721	1,399,721		1,399,721		1,399,721			22
23	Inservice Training & Education											23
24	Travel and Seminar			706	706		706		706			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			207,623	207,623		207,623		207,623			26
27	Other (specify):*											27
28	TOTAL General Administration	227,640	5,015	1,789,371	2,022,026		2,022,026	(454)	2,021,572			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,415,338	345,123	2,454,994	5,215,455		5,215,455	(5,958)	5,209,497			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
1/1/2025 - 12/31/2025

Page 3 Supplemental Schedule - Reclassification Detail

Description	Census Days	Employees	Factor	Meals Served	% of Food Cost	Allowable Food	Facility	Resident Portion	Employee Portion
Resident Meals									
Resident Census	9,902		3	29,706	76.50%	202,366	SNF	154,811	
Employee Meals									
Employees		25	365	9,125	23.50%	202,366	SNF		47,555
Total				38,831	100.00%			154,811	47,555

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			187,886	187,886		187,886	198,499	386,385			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,999	27,999		27,999		27,999			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			7,303	7,303		7,303		7,303			35
36	Other (specify):*											36
37	TOTAL Ownership			223,188	223,188		223,188	198,499	421,687			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	208,018	57,893	3,600	269,511		269,511		269,511			39
40	Barber and Beauty Shops			7,430	7,430		7,430		7,430			40
41	Coffee and Gift Shops		633		633		633		633			41
42	Provider Participation Fee			70,860	70,860		70,860		70,860			42
43	Other (specify):* See Att Sch 4A	2,637,485	521,560	3,606,579	6,765,624		6,765,624	(175,300)	6,590,324			43
44	TOTAL Special Cost Centers	2,845,503	580,086	3,688,469	7,114,058		7,114,058	(175,300)	6,938,758			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	5,260,841	925,209	6,366,651	12,552,701		12,552,701	17,241	12,569,942			45

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

Evenglow Lodge

Period Beginning 1/1/2025
Period End 12/31/2025

Schedule 4A

V. Cost Center Expenses

		Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	Ancillary Expense											
	E. Special Cost Centers											
43												
	Skyline Apartments			49,008	49,008		49,008		49,008			
	The Lodge at Evenglow-AL	1,157,884	438,434	2,648,738	4,245,056		4,245,056		4,245,056			
	Evenglow Inn Expenses	1,422,682	83,126	423,541	1,929,349		1,929,349		1,929,349			
	Other Non-Care Expenses			366,911	366,911		366,911		366,911			
	Non-Allowable Expenses	56,919		118,381	175,300		175,300	(175,300)	0	n		
	TOTAL Other Special Cost Cent	2,637,485	521,560	3,606,579	6,765,624	0	6,765,624	(175,300)	6,590,324			

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	(20)	2		4
5	Telephone, TV & Radio in Resident Rooms	(77,555)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	198,499	30		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	(379)	20		17
18	Fines and Penalties	(5,141)	43		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	(9,549)	43		24
25	Fund Raising, Advertising and Promotional	(26,136)	43		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 Page 5A	(62,478)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 17,241		\$	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))	\$ 17,241		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.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' PREPARATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	Political Action Committee Payments	\$ 0	20
2	Other Expenses Related to Lobbying Activities		2
3			3
4	Offset Misc Income Against Office Supplies	(75)	21
5	Capitalize Repairs Above \$2,500	(6,841)	6
6	Expense Fixed Assets Under \$2,500	1,357	6
7	Marketing/Development Wages	(56,919)	43
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
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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	(62,478)	

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
See Page Ownership Listing-1 for Board of Trustees		Evenglow Inn	Pontiac, Illinois	None		

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

X 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.

SEE ACCOUNTANTS' PREPARATION REPORT

STATE OF ILLINOIS

Ownership Listing-1

Evenglow Lodge

ID#

0008425

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)

-Owners of companies must be listed instead of company names.

-Names of trust beneficiaries must be listed.

Operator/Licensee

Building Co.

Management Co./Home Office

Place of Residence

Ownership Percentage

Ownership Percentage

Ownership Percentage

First Name

M.I.

Last Name

City

State

Ownership Percentage

Ownership Percentage

Ownership Percentage

1								1
2	Board of Directors:							2
3								3
4								4
5	Robert		Walter					5
6	John		Trewartha					6
7	Alberta		Kinate					7
8	Sharon		Arnold					8
9	Tom		Ewing					9
10	MaLinda		Hillman					10
11	Mary		Denker					11
12	Carol		Flessner					12
13	Douglas		McCoy					13
14	Doug		Swartz					14
15	Wayne		Taylor					15
16	Virginia		Danning					16
17	Joe		Vaughn					17
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73								73
74								74
75								75

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: 1/1/2025 Ending: 2/31/2025

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

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	USDA		X	Construction-Allocated Portion			\$	1,150,225	11/8/57	0.0225	\$ 27,999	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	1,150,225			\$ 27,999	9
	B. Non-Facility Related*											
10												10
11	None of the remaining debt of the Organization is attributable to the nursing home											11
12												12
13												13
14	TOTAL Non-Facility Related						\$				\$	14
15	TOTALS (line 9+line14)						\$	1,150,225			\$ 27,999	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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

B. Real Estate Taxes

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

2024 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Evenglow Lodge COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008425

CONTACT PERSON REGARDING THIS REPORT Thomas Stalter

TELEPHONE (815) 844 - 6131 FAX #: (815) 842 - 3558

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2024.

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

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach copies of the original 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

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

X. BUILDING AND GENERAL INFORMATION:

- A. Square Feet:150,368
- B. General Construction Type:ExteriorBrickFrameSteel and ConcreteNumber of Stories
- 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)
Lodge at Evenglow - 76 Unit Assisted Living
Skyline Apartments - 7 Independent Living Units (7th Floor of the Memorial Building)-This was closed in 2024

- F. List the bed capacity for the building if it differs from the licensed total.N/A
- G. Have you properly capitalized all major repairs and equipment purchases?Yes
- H. Are you presently operating under a sale and leaseback arrangement?No
If YES, give effective date of lease.N/A
- I. Are you presently operating under a sublease agreement?
- J. Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?
YESNOX 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

- K. 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:N/A
2. Number of Years Over Which it is Being Amortized:N/A
3. Current Period Amortization:N/A
4. Dates Incurred:N/A

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

XI. OWNERSHIP COSTS:

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	189		1962	1962	\$ 103,515	\$	40	\$	\$	\$ 103,515	4
5			1963	1963	1,794,010		40			1,794,010	5
6			1984	1984	3,561,779		40			3,561,779	6
7											7
8											8
	Improvement Type**										
9	Various		1963		71,429		15			71,429	9
10	Various		1964		542		15			542	10
11	Various		1965		2,354		15			2,354	11
12	Various		1969		1,485		15			1,485	12
13	Various		1974		1,865		15			1,865	13
14	Various		1977		5,000		15			5,000	14
15	Various		1978		2,670		15			2,670	15
16	Various		1979		2,839		15			2,839	16
17	Various		1980		677		15			677	17
18	Various		1981		1,368		15			1,368	18
19	Various		1982		11,306		15			11,306	19
20	Various		1984		25,366		15			25,366	20
21	Various		1985		2,899		15			2,899	21
22	Various		1986		58,125		15			58,125	22
23	Various		1987		9,819		15			9,819	23
24	Various		1988		6,792		15			6,792	24
25	Various		1989		57,731		15			57,731	25
26	Various		1990		129,555		15			129,555	26
27	Various		1991		82,631		15			82,631	27
28	Various		1992		75,578		15			75,578	28
29	Various		1993		48,418		15			48,418	29
30	Various		1994		12,155		15			12,155	30
31	Various		1995		91,499		15			91,499	31
32	Various		1996		223,735		15			223,735	32
33	Various		1997		131,074		15			131,074	33
34	Various		1998		133,503		15			133,503	34
35	Various		1999		17,677		15			17,677	35
36	Various		2000		128,114		15			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

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

1/1/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2001	\$ 12,764	\$	15	\$	\$	\$ 12,764	37
38	Various	2002	36,542		15			36,542	38
39	Various	2003	29,269		15			29,269	39
40	Various	2004	35,991		15			35,991	40
41	Various	2005	140,824		15			140,824	41
42	Various	2006	76,473		15			76,473	42
43	Various	2007	88,795		15			88,795	43
44	Various	2008	689,569		15			689,569	44
45	Various	2009	1,048,639		15			1,048,639	45
46	Various	2009	73,515		15			73,515	46
47	Various	2010	640,288		15	42,686	42,686	640,288	47
48	Various	2011	48,181		15	3,212	3,212	44,969	48
49	Various	2012	384,634		15	25,642	25,642	333,350	49
50	Various	2013	387,335		15	25,822	25,822	309,869	50
51	Various	2014	1,648,209		15	109,881	109,881	1,208,685	51
52	Various	2015	97,543		15	6,503	6,503	65,028	52
53	Various	2016	624,818		15	41,655	41,655	374,888	53
54	Shower Installations (Room 204, 216, 304, 404 & 409)	2017	18,041		15	1,203	1,203	9,620	54
55	Carpeting (Rooms 215, 320, 321, 417, 418, 606, 612 and ADON)	2017	6,041		15	403	403	3,220	55
56	AC Unit - Kitchen including Fending for Outside Unit	2017	104,526		15	6,968	6,968	55,750	56
57	Boiler - Evaluation, Side Stream Unit, and Coil Replacement	2017	81,151		15	5,410	5,410	43,281	57
58	Flooring and Drapery - Dining Room	2017	40,285		15	2,686	2,686	21,483	58
59	Crash Bards, Doors, and Fire Holders	2017	11,684		15	779	779	6,231	59
60	Carpet (Chapel, 202, 415, 622, 4th & 5th Floor Hallway	2018	35,650		15	2,377	2,377	16,634	60
61	Docking Station (Exterior next to Generator)	2018	46,636		15	3,109	3,109	21,764	61
62	Electrical Outlets (All resident rooms)	2018	4,272		15	285	285	1,992	62
63	Electrical Panel Upgrade	2018	6,197		15	413	413	2,893	63
64	Fire Doors	2018	6,873		15	458	458	3,209	64
65	Gardner Room (Paint, Electrical, Ceiling Tile, Plumbing, Etc.)	2018	37,325		15	2,488	2,488	17,421	65
66	Shower Conversion (Rms. 208, 504, 606)	2018	12,284		15	819	819	5,732	66
67	Sidewalk Replacement (Exterior next to generator)	2018	11,131		15	742	742	5,195	67
68	Steam Trap	2018	3,348		15	223	223	1,564	68
69	Carpet (6th Floor Planks & Rooms 610, 611, and 409)	2019	13,783		15	919	919	5,512	69
70	TOTAL (lines 4 thru 69)		\$ 13,298,126	\$		\$ 284,683	\$ 284,683	\$ 12,226,469	70

SEE ACCOUNTANTS' PREPARATION REPORT

**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:

1/1/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 13,298,126	\$		\$ 284,683	\$ 284,683	\$ 12,226,469	1
2	Steam Coil	2019	7,797		15	520	520	3,117	2
3	Water Heater Replacement	2019	11,608		15	774	774	4,642	3
4	Generator Breaker Switch	2019	33,600		15	2,240	2,240	13,440	4
5	Loading Dock Concrete Pad, Lock, and Key	2019	87,157		15	5,810	5,810	34,867	5
6	Fuel Tank	2019	29,060		15	1,937	1,937	11,627	6
7	Carpeting (Rooms 215 - 218, 412 - 414)	2020	4,711		15	314	314	1,571	7
8	Door (Holders, Levers, Locks & Keys)	2020	3,043		15	203	203	1,013	8
9	Water Heater	2020	11,608		15	774	774	3,868	9
10	Replace Actuator/Sight Glass/Gas Valves on Boiler	2021	5,774		15	385	385	1,539	10
11	Installed Expansion Tank and Drain Lines on Water Heater	2021	2,823		15	188	188	755	11
12	New Coil for Chapel Unit Vent	2021	3,300		15	220	220	880	12
13	Replaced Boiler Circuit Board	2021	4,171		15	278	278	1,113	13
14	Replace and Install Gaskets on Boiler	2021	4,100		15	273	273	1,097	14
15	Water Heater Replacement	2021	24,642		15	1,643	1,643	6,569	15
16	Water Heater Replacement	2021	27,836		15	1,856	1,856	7,420	16
17	Carpeting (Rooms 220 - 221, 514, 615 - 617)	2021	8,325		15	555	555	2,220	17
18	Call Pendant System Upgrade	2021	3,121		15	208	208	833	18
19	Replace 1st Floor Health Center Flooring	2022	10,162		15	677	677	2,038	19
20	Nurse Call System	2022	38,165		15	2,544	2,544	7,637	20
21	Electrical Upgrades-1st and 2nd Floor Kitchenette	2022	4,877		15	325	325	977	21
22	Electrical Work-Maintenance Office	2022	4,949		15	330	330	989	22
23	Repair Boiler-Replaced All Tubes/Tube Sheets (Aldrich Boiler)	2023	32,460		15	2,164	2,164	6,492	23
24	Reassemble Burner on Boiler	2023	5,382		15	359	359	1,077	24
25	Replace Radiators	2023	9,028		15	602	602	1,806	25
26	Replace Speed Drive-Rooftop Unit	2023	8,374		15	558	558	1,674	26
27	Replace Shut Off Valves on Sprinklers	2024	9,108		15	607	607	911	27
28	Install and Program New Drive and Motor for Roof Top Unit	2024	3,750		15	250	250	375	28
29	New Health Center Annex	2025	1,150,225		25	23,005	23,005	23,005	29
30	Replace Fan Motor on Compressor-Freezer	2025	2,803		15	93	93	93	30
31	Install New RPZ Valve on Fire Suppression System	2025	10,412		15	347	347	347	31
32	Replace 3 CO Detectors	2025	3,192		15	106	106	106	32
33	Replace Firm Alarm Panel	2025	3,649		15	122	122	122	33
34	TOTAL (lines 1 thru 33)		\$ 14,867,338	\$		\$ 334,950	\$ 334,950	\$ 12,370,689	34

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 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 12B, Carried Forward		\$ 14,867,338	\$		\$ 334,950	\$ 334,950	\$ 12,370,689	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13	Financial Statement Depreciation Expense			187,886			(187,886)		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	TOTAL (lines 1 thru 33)		\$ 14,867,338	\$ 187,886		\$ 334,950	\$ 147,064	\$ 12,370,689	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	\$ 2,513,915	\$	\$ 41,540	\$ 41,540	10 Yrs	\$ 1,857,656	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,513,915	\$	\$ 41,540	\$ 41,540		\$ 1,857,656	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	\$	\$	\$	5	\$ 56,130	76
77	Facility	Bus and Hitch	2001 / 2019	64,487		6,174	6,174	5-10	42,879	77
78	Facility	Van / Tractor	2010	4,700				10	4,700	78
79	Facility	2019 Ford F150	2022	33,489		3,721	3,721	9	11,164	79
80	TOTALS			\$ 158,806	\$	\$ 9,895	\$ 9,895		\$ 114,873	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 17,617,089	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 187,886	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 386,385	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 198,499	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 14,343,218	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	\$ 446,446	\$ 4,213	\$ 430,436	86
87	Evenglow Inn	5,128,469	128,085	2,785,986	87
88	303/304/308 E. Madison Street	319,003		47,724	88
89	The Lodge at Evenglow (AL)	26,641,278	507,009	1,958,921	89
90					90
91	TOTALS	\$ 32,535,196	\$ 639,307	\$ 5,223,067	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								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?
16. Rental Amount for movable equipment: \$ 7,303 Description: Copiers
- ☐ YES☐ NO
- (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	N/A		\$	\$	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.

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES

☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER CNA

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER CNA

B. EXPENSES

ALLOCATION OF COSTS (d)

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

- (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(1)	2349	hrs	\$ 108,796		\$	2,349	\$ 108,796	1
2	Licensed Speech and Language Development Therapist	39(1)	100	hrs	5,664			100	5,664	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	39(1)	2273	hrs	93,558			2,273	93,558	4
5	Physician Care			visits						5
6	Dental Care			visits						6
7	Work Related Program			hrs						7
8	Habilitation			hrs						8
9	Pharmacy	39(2)		# of prescrpts			57,893		57,893	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify):									12
13	Other (specify): Laboratory	39(3)				3,600			3,600	13
14	TOTAL				\$ 208,018	\$ 3,600	\$ 57,893	4,722	\$ 269,511	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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,364,780	\$ 2,364,780	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 338,983)	413,080	413,080	3
4	Supply Inventory (priced at Cost)	74,967	74,967	4
5	Short-Term Investments			5
6	Prepaid Insurance	79,865	79,865	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	23,411	23,411	8
9	Other(specify): See Attached Schedule 17A	244,776	244,776	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,200,879	\$ 3,200,879	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	8,330,696	8,330,696	12
13	Land	142,847	77,030	13
14	Buildings, at Historical Cost	15,463,060	14,867,338	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,140,050	2,672,721	16
17	Accumulated Depreciation (book methods)	(15,252,283)	(14,343,218)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Non Care Assets	27,404,053	27,312,129	22
23	Other(specify): See Attached Schedule 17A	7,534,955	7,534,955	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 45,763,378	\$ 46,451,651	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 48,964,257	\$ 49,652,530	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 914,314	\$ 914,314	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	423,280	423,280	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	18,856	18,856	31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,920	26,920	32
33	Accrued Interest Payable	68,992	68,992	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deposits	13,260	13,260	36
37	See Attached Schedule 17A	76,119	76,119	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,541,741	\$ 1,541,741	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,150,225	1,150,225	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	ARO Liability	636,003	636,003	43
44	Construction Loan Payable	23,399,084	23,399,084	44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 25,185,312	\$ 25,185,312	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 26,727,053	\$ 26,727,053	46
47	TOTAL EQUITY (page 18, line 24)	\$ 22,237,204	\$ 22,925,477	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 48,964,257	\$ 49,652,530	48

Facility Name:Evenglow Lodge

IDPH License ID Number:0008425

Fiscal Year End:12/31/2025

Schedule 17A

XV. Balance Sheet

Line 9 Other Current Assets (specify):

Description	Operating	After Consolidation
Accrued Interest & Dividends	38,865	38,865
Estates Receivable	205,911	205,911
Total - Line 9	244,776	244,776

Line 23 Other Assets (specify):

Description	Operating	After Consolidation
Beneficial Interest in Perpetual Trust	7,453,983	7,453,983
Assets Limited To Use	80,972	80,972
Total - Line 23	7,534,955	7,534,955

Line 37 Other Current Liabilities (specify):

Description	Operating	After Consolidation
Charitable Gift Payable	19,935	19,935
Deferred Revenue-Grants	56,184	56,184
Total - Line 37	76,119	76,119

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 21,811,006	1
2	Restatements (describe):		2
3	See Attached Schedule 18A	2,295,122	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 24,106,128	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,868,924)	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)	\$ (1,868,924)	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)	\$ 22,237,204	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:

Evenglow Lodge

IDPH License ID Number:

0008425

Fiscal Year End:

12/31/2025

Schedule 18A

XVI. STATEMENT OF CHANGES IN EQUITY

-

Line 3 Restatements:

Description	Amount
Post Closing Adj-AR/Revenues	(60,778)
Post Closing Adj-Accd PR	(119,314)
Post Closing Adj-Depreciation	(386,671)
Post Closing Adj-Investment Income	272,962
Post Closing Adj-Bad Debts	(134,075)
Post Closing Adj-Employee Retention Credit	2,312,973
Post Closing Adj-Deposit Liability	30,610
Post Closing Adj-Prepaid Insurance/Expenses	17,374
Post Closing Adj-Various Client Accruals/Adj	362,041
Total - Line 3	2,295,122

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning: 1/1/2025

Ending: 12/31/2025

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	\$ 3,430,839	1
2	Discounts and Allowances for all Levels	(183,654)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,247,185	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	7,681	13
14	Non-Patient Meals	20	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,810	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	78,801	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 93,312	23
	D. Non-Operating Revenue		
24	Contributions	87,121	24
25	Interest and Other Investment Income***	1,465,744	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,552,865	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Attached Schedule 19A</u>	5,790,415	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,790,415	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,683,777	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,257,859	31
32	Health Care	1,935,570	32
33	General Administration	2,022,026	33
	B. Capital Expense		
34	Ownership	223,188	34
	C. Ancillary Expense		
35	Special Cost Centers	7,043,198	35
36	Provider Participation Fee	70,860	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 12,552,701	40
41	Income before Income Taxes (line 30 minus line 40)**	(1,868,924)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (1,868,924)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 269,291	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	437,436	45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	1,795,870	48
49	Medicare Part A	584,743	49
50	Other-(specify)	159,845	50
51	Other-(specify)		51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 3,247,185	56

SEE ACCOUNTANTS' PREPARATION REPORT

Facility Name:Evenglow Lodge

IDPH License ID Number:0008425

Fiscal Year End:12/31/2025

Schedule 19A

XVII. Income Statement

Line 28 Other Income (specify):

Description	Operating
Evenglow Inn	2,465,528
The Lodge at Evenglow (AL)	3,310,745
Miscellaneous Income	75
Scrap Metal	74
Quality Incentive Payment	13,993
Total - Line 28	5,790,415

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	2,000	2,080	\$ 82,803	\$ 39.81	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,211	5,757	237,049	41.18	3
4	Licensed Practical Nurses	5,181	5,786	208,911	36.11	4
5	CNAs & Orderlies	28,010	30,320	799,381	26.36	5
6	CNA Trainees					6
7	Licensed Therapist	4,540	4,723	208,018	44.04	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	1,531	1,652	31,986	19.36	10
11	Social Service Workers	2,563	2,670	74,390	27.86	11
12	Dietician					12
13	Food Service Supervisor	1,560	1,560	55,763	35.75	13
14	Head Cook	7,674	8,202	140,763	17.16	14
15	Cook Helpers/Assistants	13,265	14,109	219,678	15.57	15
16	Dishwashers					16
17	Maintenance Workers	2,448	2,625	64,531	24.58	17
18	Housekeepers	8,396	9,166	121,774	13.29	18
19	Laundry					19
20	Administrator	840	874	72,180	82.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,031	6,469	155,460	24.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,000	2,080	55,891	26.87	31
32	Other Health Care(specify)					32
33	Other(specify) See Pg 20A	98,651	106,306	2,732,263	25.70	33
34	TOTAL (lines 1 - 33)	189,901	204,379	\$ 5,260,841 *	\$ 25.74	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	118	\$ 14,996	L1, C3	35
36	Medical Director	Monthly	19,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	110	5,525	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	141	9,595	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	369	\$ 49,616		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	326	\$ 23,371	L10, C3	50
51	Licensed Practical Nurses	1,375	122,564	L10, C3	51
52	Certified Nurse Assistants/Aides	1,184	41,957	L10, C3	52
53	TOTAL (lines 50 - 52)	2,885	\$ 187,892		53

SEE ACCOUNTANTS' PREPARATION REPORT

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

** See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.
- | Association Name | Amount |
|--|--------------------|
| <u>LEADING AGE</u> | <u>4,298</u> |
| <u>Other, please specify Illinois Aging Services Network</u> | <u>1,892</u> |
| | <u>6,190</u> Total |
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.
- | | |
|--|-------|
| <u>LEADING AGE</u> | |
| <u>Other, please specify Illinois Aging Services Network</u> | |
| | |
| | Total |
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)
- | | |
|--|--------------------|
| <u>LEADING AGE</u> | <u>4,298</u> |
| <u>Other, please specify Illinois Aging Services Network</u> | <u>1,892</u> |
| | <u>6,190</u> Total |
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ 35,067 Line 10
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 70,860
This amount is to be recorded on line 42 of Schedule V.
- (8) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (10) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? See Pg. 11 Sec 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.
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 47,555 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 20
- (12) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% Line 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (13) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Sikich LLP
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. N/A
Attach invoices and a summary of services for all architect and appraisal fees.