

Facility Name & ID Number Evenglow Lodge

0008425 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

	1	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	73	Skilled (SNF)	73	26,645	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	141	Sheltered Care (SC)	141	51,465	5
6		ICF/DD 16 or Less			6
7	214	TOTALS	214	78,110	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				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,012	13,355	3,917	22,284	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		23,709		23,709	12
13	DD 16 OR LESS					13
14	TOTALS	5,012	37,064	3,917	45,993	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.88%

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

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
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 2,682

Medicare Intermediary National Government Services, Inc.

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/15 Fiscal Year: 12/31/15

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	581,485	23,815	13,852	619,152		619,152		619,152		1
2	Food Purchase		367,931		367,931	(50,399)	317,532	(21,175)	296,357		2
3	Housekeeping	262,758	57,778		320,536		320,536		320,536		3
4	Laundry										4
5	Heat and Other Utilities			284,785	284,785		284,785	(15,510)	269,275		5
6	Maintenance	101,228	46,979	134,469	282,676		282,676	14,958	297,634		6
7	Other (specify):* See Supplemental										7
8	TOTAL General Services	945,471	496,503	433,106	1,875,080	(50,399)	1,824,681	(21,727)	1,802,954		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,005,727	160,004	11,753	2,177,484		2,177,484		2,177,484		10
10a	Therapy										10a
11	Activities	125,371	13,262	5,439	144,072		144,072		144,072		11
12	Social Services	38,915			38,915		38,915		38,915		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):* See Supplemental										15
16	TOTAL Health Care and Programs	2,170,013	173,266	41,192	2,384,471		2,384,471		2,384,471		16
	C. General Administration										
17	Administrative	125,893			125,893		125,893		125,893		17
18	Directors Fees										18
19	Professional Services			27,714	27,714		27,714	(5,000)	22,714		19
20	Dues, Fees, Subscriptions & Promotions			37,581	37,581		37,581		37,581		20
21	Clerical & General Office Expenses	286,874	29,587	461,283	777,744		777,744	(336,941)	440,803		21
22	Employee Benefits & Payroll Taxes			1,004,750	1,004,750	50,399	1,055,149		1,055,149		22
23	Inservice Training & Education										23
24	Travel and Seminar			9,984	9,984		9,984	(611)	9,373		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			134,294	134,294		134,294		134,294		26
27	Other (specify):* See Supplemental										27
28	TOTAL General Administration	412,767	29,587	1,675,606	2,117,960	50,399	2,168,359	(342,552)	1,825,807		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,528,251	699,356	2,149,904	6,377,511		6,377,511	(364,279)	6,013,232		29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

**Evenglow Lodge
Medicaid Cost Report
01/01/15 - 12/31/15**

Page 3 Reclass

Description	Meals Served	Resident Meals	Employee Meals
Employees Meals			
Employees	60		
Meals Per Day	1		
Days in Year	365		
Meals Served Per Year	<u>21,900</u>		13.70%
Evenglow Lodge Residents			
Census	45,993		
Meals Per Day	3		
Meals Served Per year	<u>137,979</u>	86.30%	
Total Meals Served	<u>159,879</u>	86.30%	13.70%
Food Cost			
Page 3 Line 2 Column 2	367,931		
Pre-Allocation Adjustments	(21,175)		
Meal Income - Page 5			
Food Cost For Allocation	367,931	367,931	367,931
Allocated Food Cost		<u>317,532</u>	<u>50,399</u>

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			618,104	618,104		618,104		618,104		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										35
36	Other (specify):* See Supplemental										36
37	TOTAL Ownership			618,104	618,104		618,104		618,104		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		122,432	422,280	544,712		544,712		544,712		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			159,028	159,028		159,028		159,028		42
43	Other (specify):* See Supplemental	943,827	150,548	660,019	1,754,394		1,754,394	(1,754,394)			43
44	TOTAL Special Cost Centers	943,827	272,980	1,241,327	2,458,134		2,458,134	(1,754,394)	703,740		44
	GRAND TOTAL COST										
45	(sum of lines 29, 37 & 44)	4,472,078	972,336	4,009,335	9,453,749		9,453,749	(2,118,673)	7,335,076		45

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Evenglow Lodge
Medicaid Cost Report
01/01/15 - 12/31/15**

Page 4 Supplemental Schedule

Description	Salaries	Supplies	Other
Line 36 Detailed			
Total	-	-	-
Line 43 Detailed			
Marketing and Development	78,602	5,775	52,585
Evenglow Inn	845,245	136,190	527,581
Skyline Apartments	19,980	2,999	77,205
Wellness Program		5,584	2,648
Total	943,827	150,548	660,019

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(21,175)	02		4
5	Telephone, TV & Radio in Resident Rooms	(15,510)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(288,477)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Supplemental	(1,793,511)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,118,673)		\$	30

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	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,118,673)		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	2	3	4	
		Yes	No	Amount	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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Evenglow Lodge

ID# 0008425

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Legal Fees - Retainer	\$ (5,000)	19	1
2	Investment Fees	(43,379)	21	2
3	Flowers	(3,810)	21	3
4	Miscellaneous Income	(1,275)	21	4
5	Travel and Seminar	(611)	24	5
6	Marketing and Development	(136,962)	43	6
7	Evenglow Inn	(1,509,016)	43	7
8	Skyline Apartments	(100,184)	43	8
9	Wellness Program	(8,232)	43	9
10	Capitalized Assets < \$2,500	14,958	06	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,793,511)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Evenglow Lodge# 0008425

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Operating Expenses	PAGES	PAGE	SUMMARY										
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(21,175)	0	0	0	0	0	0	0	0	0	0	(21,175)	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	(15,510)	0	0	0	0	0	0	0	0	0	0	(15,510)	5
6	Maintenance	14,958	0	0	0	0	0	0	0	0	0	0	14,958	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(21,727)	0	(21,727)	8									
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,000)	0	0	0	0	0	0	0	0	0	0	(5,000)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(336,941)	0	0	0	0	0	0	0	0	0	0	(336,941)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(611)	0	0	0	0	0	0	0	0	0	0	(611)	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	(342,552)	0	(342,552)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(364,279)	0	(364,279)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	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	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,754,394)	0	0	0	0	0	0	0	0	0	0	(1,754,394)	43
44	TOTAL Special Cost Centers	(1,754,394)	0	0	0	0	0	0	0	0	0	0	(1,754,394)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(2,118,673)	0	0	0	0	0	0	0	0	0	0	(2,118,673)	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.

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V		\$			\$	\$		1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$			\$	\$ *		14

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES (continued)

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/15

Ending: 12/31/15

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____)

Fax Number (_____)

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge # 0008425 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	N/A									1										
2										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. \$ 0 Line # N/A

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

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

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2014 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 2015 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:	2010	8
	2011	9
	2012	10
	2013	11
	2014	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2014	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

N/A - Non Profit Organization

NOTES:

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/15 Ending:

12/31/15

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 Lodge - 26 Sheltered Care Beds (Separate IDPH License)

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

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

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

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

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

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	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' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$		\$	\$	\$	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	Fire System (Door Closer, Fire Dampers)	2012	2,469						49
50	Steamer Repair	2012	5,859						50
51	Chiller Repair (Circuit Replacement)	2012	4,217						51
52	Boiler Repair	2012	7,534						52
53	Driveway Grate System - ****	2012	9,696						53
54	Landscaping - ****	2012	5,391						54
55	Canopy and Architectural Costs - ****	2012	243,304						55
56	2nd / 3rd Floors (Signs, Carpeting, Wallpaper, Paint,								56
57	Consulting, Showers, Corner Guards, Concrete Work) ****	2012	98,538						57
58	Water Heaters	2012	7,626						58
59	Nurse Call System - HC Center - ****	2013	65,184						59
60	Sprinkler System Upgrade - HC Center	2013	13,595						60
61	Water Heater Expansion Packs	2013	6,904						61
62	2nd/3rd/4th Floors (Carpeting, Showers, Cabinets, Blinds)	2013	15,904						62
63	Phone System - Entire Building - ****	2013							63
64	2nd/3rd/4th Floors (Carpeting, Showers, Cabinets, Blinds)	2013	2,590						64
65	Air Handling Unit	2013	150,300						65
66	Granny Gates - Stairwells	2013	3,311						66
67	Upgrading Cable & Wiring	2013	29,214						67
68	Ceiling Tiles - Hallways	2013	5,816						68
69	Ductwork / Dampers - Dryer Room	2013	9,060						69
70	TOTAL (lines 4 thru 69)		\$ 10,402,872	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION 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:

01/01/15

Ending:

12/31/15

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,402,872	\$		\$	\$	\$	1
2	Roof Repairs - Health Center	2013	16,120						2
3	Grease Trap	2013	2,953						3
4	Laundry Room Ejector Pumps	2013	3,387						4
5	Nurse Call System - HC Center	2013	37,829						5
6	Backflow Preventor / Recirculating Pump	2013	19,061						6
7	Brick Work - Exterior of Building	2013	6,107						7
8	Weatherstripping - Exterior Doors / Windows	2014	5,148						8
9	Hot Water Heater and Mixing Valves	2014	25,150						9
10	Carpeting (Rms. 222 - 224, 319, and 508)	2014	3,163						10
11	Elevator - Pit Ladders	2014	4,029						11
12	Nurse Call System / Wanderguard System	2014	52,737						12
13	Air Handling Unit	2014	20,527						13
14	Electrical Outlets - Resident Rooms (2nd and 3rd Floors)	2014	17,640						14
15	Plenum and Duct Work Replacement	2014	1,510,733						15
16	Elevator Upgrades	2014	9,082						16
17	Boiler - Retube	2015	20,992						17
18	Pressure Pump System	2015	28,516						18
19	Carpeting (Rms. 208,507,511,512,604,605,610,611,617,618 & BO)	2015	8,591						19
20	Shower Units (Apt. 507,508,511, and 512)	2015	18,357						20
21	Plenum and Duct Work Replacement - Final Work Orders	2015	7,061						21
22	Therapy Room - Painting, Signs, Asbestos Removal	2015	10,926						22
23	Kitchen Unit (Apt. 610 and 611)	2015	3,100						23
24									24
25									25
26									26
27									27
28									28
29	**** - Line items adjusted per 06/30/13 Capital Report Audit								29
30	++++ - Line items adjusted per 06/30/15 Capital Report Audit								30
31									31
32	Financial Statement Depreciation			526,848		526,848		8,700,677	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 12,234,081	\$ 526,848		\$ 526,848	\$	\$ 8,700,677	34

SEE ACCOUNTANTS' COMPILATION 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: 01/01/15 Ending: 12/31/15

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	\$ 2,233,870	\$ 74,065	\$ 74,065	\$		\$ 1,190,157	71
72	Current Year Purchases	110,352	11,174	11,174			11,174	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,344,222	\$ 85,239	\$ 85,239	\$		\$ 1,201,331	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Van	2012	\$ 17,545	\$ 3,509	\$ 3,509	\$		\$ 12,282	76
77	Facility	Bus and Hitch	2001 / 2004	46,630					46,630	77
78	Facility	Pick-Up Truck	2009	9,231	1,319	1,319			8,463	78
79	Facility	Van / Tractor	2010	12,200	1,189	1,189			10,085	79
80	TOTALS			\$ 85,606	\$ 6,017	\$ 6,017	\$		\$ 77,460	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,740,939	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 618,104	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 618,104	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 9,979,468	85

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

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Skyline Apartment	\$ 421,417	\$ 7,440	\$ 322,464	86
87	Evenglow Inn	4,761,588	115,456	1,610,277	87
88	303 E Madison Street	66,200	1,870	2,780	88
89					89
90					90
91	TOTALS	\$ 5,249,205	\$ 124,766	\$ 1,935,521	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' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning: 01/01/15

Ending: 12/31/15

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	_____ /2016	\$ _____
13.	_____ /2017	\$ _____
14.	_____ /2018	\$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	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	
					Units	Cost						
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1		
2	Licensed Speech and Language Development Therapist		hrs							2		
3	Licensed Recreational Therapist		hrs							3		
4	Licensed Physical Therapist		hrs							4		
5	Physician Care		visits							5		
6	Dental Care		visits							6		
7	Work Related Program		hrs							7		
8	Habilitation		hrs							8		
9	Pharmacy	39 - 02	# of prescripts				100,724		100,724	9		
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10		
11	Academic Education		hrs							11		
12	Other (specify): See Supplemental	39 - 02					21,708		21,708	12		
13	Other (specify): See Supplemental	39 - 03					422,280		422,280	13		
14	TOTAL			\$		\$	422,280	\$	122,432	\$	544,712	14

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning: 01/01/15

Ending:

12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(last day of reporting year)

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	\$ 1,175,925	\$	1
2	Cash-Patient Deposits	33,807		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 515,000)	963,412		3
4	Supply Inventory (priced at Cost - FIFO)	63,809		4
5	Short-Term Investments	4,213,163		5
6	Prepaid Insurance	99,101		6
7	Other Prepaid Expenses	59,807		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Supplemental Schedule	164,943		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 6,773,967	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,069,259		13
14	Buildings, at Historical Cost	16,868,305		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,067,791		16
17	Accumulated Depreciation (book methods)	(11,914,989)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	4,225,268		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 12,315,634	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 19,089,601	\$	25

		1	2	
		Operating	After	
			Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 364,031	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	33,807		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	359,229		30
31	Accrued Taxes Payable (excluding real estate taxes)	27,030		31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,564		32
33	Accrued Interest Payable	1,980		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Supplemental Schedule	440,597		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,240,238	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	426,689		41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 426,689	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,666,927	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 17,422,674	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 19,089,601	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Evenglow Lodge
Medicaid Cost Report
01/01/15 - 12/31/15

Page 17 Supplemental Schedule

Description	Operating	After Consolidation
Line 9 - Other Current Assets		
Medicare Settlement	10,822	
Accrued Interest Receivable	12,159	
Estates Receivable	141,962	
Total	164,943	-
 Line 23 - Other Long Term Assets		
Financing Costs (Net of Amortization)	10,981	
Construction in Progress	18,045	
Investments - Insurance Companies	84,441	
Beneficial Interest in Perpetual Trust	4,111,801	
Total	4,225,268	-
 Line 36 - Other Current Liabilities		
Deferred Revenue - Skyline Apartments	82,472	
Refund Liability - Skyline Apartments	358,125	
Total	440,597	-
 Line 43 - Other Long Term Liabilities		
Total	-	-

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 17,770,017	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 17,770,017	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(347,343)	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)	\$ (347,343)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 17,422,674	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	\$ 7,246,024	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,246,024	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	21,175	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	19,301	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)	\$ 40,476	23
D. Non-Operating Revenue			
24	Contributions	188,002	24
25	Interest and Other Investment Income***	37,724	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 225,726	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	1,594,180	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,594,180	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,106,406	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,875,080	31
32	Health Care	2,384,471	32
33	General Administration	2,117,960	33
B. Capital Expense			
34	Ownership	618,104	34
C. Ancillary Expense			
35	Special Cost Centers	2,299,106	35
36	Provider Participation Fee	159,028	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,453,749	40
41	Income before Income Taxes (line 30 minus line 40)**	(347,343)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (347,343)	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 603,344	44
45	Private Pay - Net Inpatient Revenue	5,113,866	45
46	Medicare - Net Inpatient Revenue	1,528,814	46
47	Other-(specify) <u>Insurance - Net Inpatient Revenue</u>		47
48	Other-(specify) <u>Veterans and Hospice - Net Inpatient Revenue</u>		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 7,246,024	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

**Evenglow Lodge
Medicaid Cost Report
01/01/15 - 12/31/15**

Page 19 Supplemental Schedule

Description	Total	Adjustment
Line 28 - Other Revenue		
Skyline Apartments (Expense Line 43)	111,938	
Evenglow Inn (Expense Line 43)	1,473,605	
Vending Commissions	60	
Wellness Program (Expense Line 43)	2,657	
Rental Property (Expense Line 43)	4,645	
Miscellaneous Income	1,275	1,275
Total	1,594,180	1,275

Facility Name & ID Number Evenglow Lodge

0008425

Report Period Beginning:

01/01/15

Ending:

12/31/15

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,896	2,072	\$ 83,093	\$ 40.10	1
2	Assistant Director of Nursing	3,763	4,414	120,153	27.22	2
3	Registered Nurses	12,960	14,570	372,737	25.58	3
4	Licensed Practical Nurses	18,821	20,841	483,858	23.22	4
5	CNAs & Orderlies	65,456	72,740	922,928	12.69	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,823	9,727	125,371	12.89	10
11	Social Service Workers	1,906	2,092	38,915	18.60	11
12	Dietician					12
13	Food Service Supervisor	3,883	4,200	79,737	18.99	13
14	Head Cook					14
15	Cook Helpers/Assistants	42,255	46,443	501,748	10.80	15
16	Dishwashers					16
17	Maintenance Workers	6,020	6,605	101,228	15.33	17
18	Housekeepers	22,027	24,795	262,758	10.60	18
19	Laundry					19
20	Administrator	1,662	1,805	125,893	69.75	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,185	15,926	286,874	18.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,771	1,902	22,958	12.07	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	54,154	61,838	943,827	15.26	33
34	TOTAL (lines 1 - 33)	259,582	289,970	\$ 4,472,078 *	\$ 15.42	34

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 13,852	01 - 03	35
36	Medical Director	24,000	09 - 03	36
37	Medical Records Consultant	2,124	10 - 03	37
38	Nurse Consultant			38
39	Pharmacist Consultant	9,526	10 - 03	39
40	Physical Therapy Consultant	103	10A - 03	40
41	Occupational Therapy Consultant			41
42	Respiratory Therapy Consultant			42
43	Speech Therapy Consultant			43
44	Activity Consultant	5,439	11 - 03	44
45	Social Service Consultant			45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	\$ 55,044		49

C. CONTRACT NURSES

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

**Evenglow Lodge
Medicaid Cost Report
01/01/15 - 12/31/15**

Page 20 Supplemental Schedule

Description	Hours Worked	Hours Paid	Salary
Other Salaries			
Marketing (Line 43)	2,331	2,552	78,602
Evenglow Inn (Line 43)	50,928	58,292	845,245
Skyline Apartments (Line 43)	895	994	19,980
Total	<u>54,154</u>	<u>61,838</u>	<u>943,827</u>

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount		
Mark Hovren	Administrator	0	\$ 125,893	Workers' Compensation Insurance	\$ 116,690	IDPH License Fee	\$ 1,990		
				Unemployment Compensation Insurance	4,509	Advertising: Employee Recruitment	6,253		
				FICA Taxes	263,996	Health Care Worker Background Check (Indicate # of checks performed)			
				Employee Health Insurance	525,646	<u>Patient Background Checks</u>			
				Employee Meals	50,399	Subscriptions	3,561		
				Illinois Municipal Retirement Fund (IMRF)*		Licenses and Dues	25,777		
				401K Matching Contributions	73,219				
				Employee Benefits - Other	20,690				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 125,893						
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount	
			\$	Employee Benefits - Classified to Line 43		233,850	Less: Public Relations Expense	()	
				Employee Benefits - Disallowed Page 5		(233,850)	Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,055,149	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 37,581
C. Professional Services									
Vendor/Payee	Type		Amount						
Robert A. Kearney	Legal		\$ 5,000				Out-of-State Travel	\$ 611	
Polsinelli Shughart	Legal		1,503				Non-Allowable	(611)	
Jeremy Brune & Associates, LLC	Accounting / Auditing		21,211				In-State Travel	1,602	
							Seminar Expense	7,771	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 27,714	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 9,373

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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

(See instructions.)

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

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Leading Age - \$8,726
- (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.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 159,028
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes - See Page 12 For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 50,399 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 21,175
- (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? N/A
 - 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 of Schedule V? Yes
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees