FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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: 0033977

Facility Name: Atrium Health Care Center

Address: 1425 Estes Avenue (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 973-4780 **Fax #** (773) 973-1895

HFS ID Number:

Date of Initial License for Current Owners: 1988

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/18 to 12/31/18 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)
** Subject to the attached Accountants' Consulting Report* (Date)
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	160	58,400	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,492	445	2,559	20,496	8
9	SNF/PED					9
10	ICF	33,809	127	517	34,453	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	51,301	572	3,076	54,949	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.09%

D. How many bed reserve days during this year were paid by the Department?
None (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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/1/1988

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/1/1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 116 and days of care provided 2,559

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	299,456	76,487	10,045	385,988		385,988	13,609	399,597			1
2	Food Purchase		292,577		292,577	(44,895)	247,682	(30)	247,652			2
3	Housekeeping	213,471	34,322		247,793		247,793		247,793			3
4	Laundry	79,077	15,520		94,597		94,597		94,597			4
5	Heat and Other Utilities			158,424	158,424		158,424	(6,639)	151,785			5
6	Maintenance	105,446	26,118	79,624	211,188		211,188	(15,604)	195,584			6
7	Other (specify):*							1,948	1,948			7
8	**TOTAL General Services**	697,450	445,024	248,093	1,390,567	(44,895)	1,345,672	(6,716)	1,338,956			8
	B. Health Care and Programs											
9	Medical Director			24,050	24,050		24,050		24,050			9
10	Nursing and Medical Records	2,098,072	64,820	27,466	2,190,358		2,190,358	(865)	2,189,493			10
10a	Therapy	33,776		4,456	38,232		38,232		38,232			10a
11	Activities	95,720	1,973	976	98,669		98,669		98,669			11
12	Social Services	102,752		5,595	108,347		108,347		108,347			12
13	CNA Training											13
14	Program Transportation			243	243		243		243			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,330,320	66,793	62,786	2,459,899		2,459,899	(865)	2,459,034			16
	C. General Administration											
17	Administrative	107,280		555,250	662,530		662,530	(443,919)	218,611			17
18	Directors Fees											18
19	Professional Services			168,323	168,323	(5,004)	163,319	(62,476)	100,843			19
20	Dues, Fees, Subscriptions & Promotions			39,787	39,787		39,787	(9,874)	29,913			20
21	Clerical & General Office Expenses	117,511	40,737	151,787	310,035		310,035	44,456	354,491			21
22	Employee Benefits & Payroll Taxes			497,562	497,562	44,895	542,457		542,457			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,384	1,384		1,384	388	1,772			24
25	Other Admin. Staff Transportation			5,349	5,349		5,349	3,546	8,895			25
26	Insurance-Prop.Liab.Malpractice			403,520	403,520		403,520	3,765	407,285			26
27	Other (specify):*							66,480	66,480			27
28	**TOTAL General Administration**	224,791	40,737	1,822,962	2,088,490	39,891	2,128,381	(397,634)	1,730,747			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,252,561	552,554	2,133,841	5,938,956	(5,004)	5,933,952	(405,215)	5,528,737			29

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

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

Facility Name & ID Number Atrium Health Care Center #0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,707	21,707		21,707	54,673	76,380			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			92	92		92	173,949	174,041			32
33	Real Estate Taxes			246,577	246,577	5,004	251,581	2,953	254,534			33
34	Rent-Facility & Grounds			2,340,000	2,340,000		2,340,000	(2,340,000)				34
35	Rent-Equipment & Vehicles							9,926	9,926			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,608,376	2,608,376	5,004	2,613,380	(2,098,499)	514,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		75,589	307,740	383,329		383,329		383,329			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			407,001	407,001		407,001		407,001			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		75,589	714,741	790,330		790,330		790,330			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,252,561	628,143	5,456,958	9,337,662		9,337,662	(2,503,714)	6,833,948			45

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,595)	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	(107,531)	30		9
10	Interest and Other Investment Income	(24,652)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(30)	02		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	(96,014)	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	(1,234)	20		28
29	Other-Attach Schedule	(110,205)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (348,261)		$	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)	(2,155,453)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,155,453)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,503,714)		37

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

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

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

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc. Income	$ (502)	21	1
2	Veterans Expense	(865)	10	2
3	Sequestration	(29,970)	21	3
4	Building Company - Accounting Fees	(1,500)	19	4
5	Building Company - IL Replacement Tax	(25,420)	21	5
6	PAC Dues	(8,640)	20	6
7	Non-Allowable Legal	(11,000)	19	7
8	Capitalized R&M	(20,844)	06	8
9	Non-Allowable Appraisal	(5,004)	19	9
10	Parking Lot Rental Income	(3,600)	06	10
11	Non-Allowable Expense	(2,860)	21	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**	(110,205)		49

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				13,609								13,609	1
2	Food Purchase	(30)											(30)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,595)		1,956									(6,639)	5
6	Maintenance	(24,444)		2,171	6,669								(15,604)	6
7	Other (specify):*				1,948								1,948	7
8	**TOTAL General Services**	(33,069)		4,127	22,226								(6,716)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(865)											(865)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(865)											(865)	16
	C. General Administration													
17	Administrative			(515,075)	71,156								(443,919)	17
18	Directors Fees													18
19	Professional Services	(17,504)	1,500	(46,887)		415							(62,476)	19
20	Fees, Subscriptions & Promotions	(9,874)											(9,874)	20
21	Clerical & General Office Expenses	(154,766)	25,420	173,802									44,456	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			388									388	24
25	Other Admin. Staff Transportation			3,546									3,546	25
26	Insurance-Prop.Liab.Malpractice			3,063		702							3,765	26
27	Other (specify):*			61,980	4,500								66,480	27
28	**TOTAL General Administration**	(182,144)	26,920	(319,183)	75,656	1,117							(397,634)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(216,078)	26,920	(315,056)	97,882	1,117							(405,215)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Atrium Health Care Center # 0033977 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	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)	
30	Depreciation	(107,531)	162,204										54,673	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(24,652)	196,772			1,829							173,949	32
33	Real Estate Taxes					2,953							2,953	33
34	Rent-Facility & Grounds		(2,340,000)	23,597		(23,597)							(2,340,000)	34
35	Rent-Equipment & Vehicles			9,926									9,926	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(132,183)	(1,981,024)	33,523		(18,815)							(2,098,499)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(348,261)	(1,954,104)	(281,533)	97,882	(17,698)							(2,503,714)	45

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 6-Supplemental		See 6-Supplemental		See 6-Supplemental		

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 2,340,000	Atrium Health Care Center LLC		$	$ (2,340,000)	1
2	V	19	Accounting Fees		Atrium Health Care Center LLC		1,500	1,500	2
3	V	32	Mortgage Interest		Atrium Health Care Center LLC		196,772	196,772	3
4	V	30	Depreciation		Atrium Health Care Center LLC		162,204	162,204	4
5	V	21	Illinois Replacement Tax		Atrium Health Care Center LLC		25,420	25,420	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			$ 2,340,000			$ 385,896	$ * (1,954,104)	14

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	STAYCARE MANAGEMENT, LTD.		$ 1,956	$ 1,956	15
16	V	6	REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.		2,171	2,171	16
17	V	17	ADMIN. SALARY		STAYCARE MANAGEMENT, LTD.		40,175	40,175	17
18	V	19	PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.		6,028	6,028	18
19	V	21	CLERICAL & GENERAL - SALARIES		STAYCARE MANAGEMENT, LTD.		177,567	177,567	19
20	V	21	CLERICAL & GENERAL - OTHER		STAYCARE MANAGEMENT, LTD.		12,855	12,855	20
21	V	24	SEMINARS		STAYCARE MANAGEMENT, LTD.		388	388	21
22	V	25	ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.		3,546	3,546	22
23	V	26	INSURANCE		STAYCARE MANAGEMENT, LTD.		3,063	3,063	23
24	V	27	EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.		61,980	61,980	24
25	V	30	DEPRECIATION		STAYCARE MANAGEMENT, LTD.				25
26	V	34	BUILDING RENT		STAYCARE MANAGEMENT, LTD.		23,597	23,597	26
27	V	35	EQUIP. RENTAL-AUTO		STAYCARE MANAGEMENT, LTD.		9,926	9,926	27
28	V								28
29	V								29
30	V	17	MANAGEMENT FEE	555,250	STAYCARE MANAGEMENT, LTD.			(555,250)	30
31	V	19	ADMINISTRATIVE CONSULT.	26,360	STAYCARE MANAGEMENT, LTD.			(26,360)	31
32	V	21	ADMISSIONS DIRECTOR	16,620	STAYCARE MANAGEMENT, LTD.			(16,620)	32
33	V	19	REIMBURSEMENT CONSULT.	26,555	STAYCARE MANAGEMENT, LTD.			(26,555)	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 624,785			$ 343,252	$ * (281,533)	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY COMP - S. WEBSTER	$	STAY CARE MANAGEMENT, LTD.		$ 3,429	$ 3,429	15
16	V	1	DIETARY COMP - D. WENGROW		STAYCARE MANAGEMENT, LTD.		10,180	10,180	16
17	V	6	MAINTENANCE COMP.		STAYCARE MANAGEMENT, LTD.		6,669	6,669	17
18	V	7	EMP. BEN. - S. WEBSTER		STAYCARE MANAGEMENT, LTD.		344	344	18
19	V	7	EMP. BEN. - D. WENGROW		STAYCARE MANAGEMENT, LTD.		888	888	19
20	V	7	EMP. BEN. - MAINT. NON-OWNER		STAYCARE MANAGEMENT, LTD.		716	716	20
21	V	17	ADMIN. COMP - H. WENGROW		STAYCARE MANAGEMENT, LTD.		14,206	14,206	21
22	V	17	ADMIN. COMP - J. WEBSTER		STAYCARE MANAGEMENT, LTD.		56,950	56,950	22
23	V	27	EMP. BEN. - H. WENGROW		STAYCARE MANAGEMENT, LTD.		940	940	23
24	V	27	EMP. BEN. - J. WEBSTER		STAYCARE MANAGEMENT, LTD.		3,560	3,560	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 97,882	$ * 97,882	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		415	$ 415	15
16	V	26	INSURANCE		DOUBLE YOU REALTY, LLC		702	702	16
17	V	30	DEPRECIATION		DOUBLE YOU REALTY, LLC				17
18	V	32	INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		1,829	1,829	18
19	V	33	REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		2,953	2,953	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V	34	RENT	23,597	DOUBLE YOU REALTY, LLC			(23,597)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 23,597			$ 5,899	$ * (17,698)	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

VII. RELATED PARTIES (continued)

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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	ABRAHAM MIKEL	0.63%	ABBINGTON REHAB & NURSING CENTER, LTD.	ROSELLE	ATRIUM HEALTHCARE LTD. P/	LINCOLNWOOD	BUILDING CO.	1
2	ABRAHAM STERN	3.13%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING CO.	2
3	ARTHUR ROTHBLATT	0.42%	HICKORY NURSING PAVILION, INC.	HICKORY HILLS	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKKEEI	3
4	BERNARD FRUCHTER	0.39%	RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				4
5	BETTE COHEN	0.21%	ZIKAINIM, INC. D/B/A ALL AMERICAN NURSING HOME	CHICAGO				5
6	CARY BUXBAUM	0.42%						6
7	DAVID WENGROW	1.25%						7
8	DINA BRAUNSTEIN	1.25%						8
9	EDWARD G ROTHBLATT FAMILY TRUST	0.42%						9
10	ELI WEBSTER	1.25%						10
11	GAIL GOODSITE REVOCABLE TRUST	0.39%						11
12	GARRY CHANKIN	0.21%						12
13	HOWARD WENGROW	30.94%						13
14	JAY WENGROW	1.25%						14
15	JEFFREY J. WEBSTER	29.69%						15
16	JEFFREY SINGER	0.42%						16
17	MARVIN FOX	0.42%						17
18	MYRNA HILL	0.42%						18
19	NOSHIR DARUWALLA	0.42%						19
20	RICHARD SGARLATA	0.42%						20
21	ROBERT A. ROSE	0.42%						21
22	SHERRY WARSO	18.75%						22
23	SHIMON WEBSTER	1.25%						23
24	STEVE SILBERMAN	0.42%						24
25	SUSAN STERN	3.13%						25
26	YAAKOV MIKEL	0.63%						26
27	YERUCHOM LEVOVITZ	1.25%						27
28	JANET CHANKIN	0.21%						28
29								29
30								30

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeffrey Webster	Owner	Administrative	29.69%	See Attached	20	28.57%	Alloc. Salary	$ 56,950	17-07	1
2	Howard Wengrow	Owner	Administrative	30.94%	See Attached	5	7.69%	Alloc. Salary	14,206	17-07	2
3	Sara Webster	Relative	Dietary	0%	See Attached	1.7	33.93%	Alloc. Salary	3,429	01-07	3
4	Deborah Wengrow	Relative	Dietary	0%	See Attached	1.7	33.93%	Alloc. Salary	10,180	01-07	4
5	Ephraim Braunstein	Relative	Clerical	0%	See Attached	10.06	25.16%	Alloc. Salary	25,358	21-07	5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 110,123		13

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

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 [X]

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 [X] NO [ ]

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

Name of Related Organization: STAYCARE MANAGEMENT, LTD.
Street Address: 3737 W ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	218,426	6	$ 7,776	$	54,949	$ 1,956	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	218,426	6	8,630		54,949	2,171	2
3	17	ADMIN. SALARY	PATIENT DAYS	218,426	6	159,698	159,698	54,949	40,175	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	218,426	6	23,962		54,949	6,028	4
5	21	CLERICAL & GENERAL - SALA	PATIENT DAYS	218,426	6	705,841	705,841	54,949	177,567	5
6	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	218,426	6	51,101		54,949	12,855	6
7	24	SEMINARS	PATIENT DAYS	218,426	6	1,541		54,949	388	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	218,426	6	14,095		54,949	3,546	8
9	26	INSURANCE	PATIENT DAYS	218,426	6	12,177		54,949	3,063	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	218,426	6	246,373		54,949	61,980	10
11	30	DEPRECIATION	PATIENT DAYS	218,426	6			54,949		11
12	34	BUILDING RENT	PATIENT DAYS	218,426	6	93,800		54,949	23,597	12
13	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	218,426	6	39,457		54,949	9,926	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					$ 1,364,451	$ 865,539		$ 343,252	25

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 [X] NO [ ]

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

Name of Related Organization: STAYCARE MANAGEMENT, LTD.
Street Address: 3737 W ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	2	3,429	1
2	1	DIETARY COMP - D. WENGRO	AVG. HOURS WORKED	5	4	30,000	30,000	2	10,180	2
3	6	MAINTENANCE COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	10	6,669	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,013		2	344	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,618		2	888	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,848		10	716	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	184,684	184,684	5	14,206	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	199,324	199,324	20	56,950	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,223		5	940	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,458		20	3,560	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					$ 481,782	$ 450,622		$ 97,882	25

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 [X] NO [ ]

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

Name of Related Organization: DOUBLE YOU REALTY, LLC
Street Address: 3737 W. ARTHUR AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: ((847) 679-2121
Fax Number: ((847) 679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	218,426	6	1,650		54,949	415	1
2	26	INSURANCE	PATIENT DAYS	218,426	6	2,791		54,949	702	2
3	30	DEPRECIATION	PATIENT DAYS	218,426	6			54,949		3
4	32	INTEREST EXPENSE	PATIENT DAYS	218,426	6	7,271		54,949	1,829	4
5	33	REAL ESTATE TAXES	PATIENT DAYS	218,426	6	11,737		54,949	2,953	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					$ 23,449	$		$ 5,899	25

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	MB Financial		X	Mortgage			$	$ 3,847,458			$ 196,772	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Misc. Interest Expense		X								92	6
7												7
8												8
9	TOTAL Facility Related						$	$ 3,847,458			$ 196,864	9
	B. Non-Facility Related*											
10	Interest Income		X								(24,652)	10
11	Alloc from Double You Realty										1,829	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (22,823)	14
15	TOTALS (line 9+line14)						$	$ 3,847,458			$ 174,041	15

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

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

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 111,043	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.)		$ 116,573	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,530	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 244,000	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.)		$ 5,004	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.		$ 254,534	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	191,361	8
	2014	195,217	9
	2015	197,905	10
	2016	216,311	11
	2017	232,591	12

2018 Accrual = 2017 tax + 5% (232,591 x 1.05 = 244,000 rounded)

Line 2 only reflects the second installment payments of the 2017 tax bills, since the first installment was paid in 2017.

Allocated from Double You Realty $2953

Beginning accrual is adjusted

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Atrium Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033977

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-32-105-005-0000	Long Term Care Property	$ 3,885.42	$ 3,885.42
2.	11-32-105-006-0000	Long Term Care Property	$ 58,563.09	$ 58,563.09
3.	11-32-105-007-0000	Long Term Care Property	$ 111,964.07	$ 111,964.07
4.	11-32-105-008-0000	Long Term Care Property	$ 58,177.92	$ 58,177.92
5.	10-35-329-014-0000	Alloc. From Double You Realty	$ 24,601.06	$ 6,188.84
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 257,191.56	$ 238,779.34

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2017 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2017 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2017.

Please complete the Real Estate Tax Statement below and include it in the 2018 cost report along with a copy of your 2017 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2017 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Atrium Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033977

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2017 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 2017.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
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 _____ NO

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

C. **Tax Bills**

Attach a copy of the original 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,312 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (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? [X] (a) Own the Equipment [X] (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).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	26,985	1975	$ 124,712	1
2	Allocated from Double You Realty LLC			12,578	2
3	TOTALS			$ 137,290	3

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	160			1972	$ 574,854	$ 162,204	33	$	$ (162,204)	$ 919,825	4
5				1972	344,971						5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1972	50,343		20				9
10	Various			1974	12,941		20				10
11	Various			1977	46,500		20				11
12	Various			1978	23,362		20				12
13	Various			1979	11,676		20			1,354	13
14	Various			1980	12,652		20			580	14
15	Various			1981	4,095		20			393	15
16	Various			1982	1,310		20			1,310	16
17	Various			1989	42,200		20			35,799	17
18	Various			1992	16,375		20			15,185	18
19	Various			1993	26,090		20			24,566	19
20	Various			1995	32,183		20			31,833	20
21	Various			1996	71,604		20			70,977	21
22	Various			1997	52,684		20			52,682	22
23	Various			1998	131,108		20	2,180	2,180	130,983	23
24	Various			1999	9,413		20	469	469	9,114	24
25	Various			2000	67,328		20	1,670	1,670	43,915	25
26	Various			2001	13,010		20	651	651	11,501	26
27	Various			2002	5,102		20			5,102	27
28	Various			2003	55,595		20	796	796	53,060	28
29	Various			2004	7,347		20	223	223	6,156	29
30	Various			2005	15,308		20	141	141	14,358	30
31	Various			2006	47,619		20	281	281	45,463	31
32	Various			2007	6,765		20	338	338	4,031	32
33	Various			2008	48,015		20	1,494	1,494	45,259	33
34	Various			2009	87,312		20	8,731	8,731	84,144	34
35	Various			2010	52,946		20	5,009	5,009	42,196	35
36	Various			2011	25,166		20	1,961	1,961	20,480	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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Various	2012	$ 148,718	$	20	$ 6,826	$ 6,826	$ 122,128	37
38	Various	2013	123,401		20	12,199	12,199	68,171	38
39	Various	2014	40,810		20	2,041	2,041	8,479	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)								67
68	Related Party Allocations (Pages 12H & 12I)		132,343			3,688	3,688	54,405	68
69	Financial Statement Depreciation			21,707			(21,707)		69
70	TOTAL (lines 4 thru 69)		$ 2,341,146	$ 183,911		$ 48,699	$ (135,212)	$ 1,923,445	70

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 12A, Carried Forward		$ 2,341,146	$ 183,911		$ 48,699	$ (135,212)	$ 1,923,445	1
2	Walk In Cooler	2015	2,516		20	252	252	902	2
3	Tuckpointing	2016	37,900		20	3,790	3,790	9,475	3
4	Fire Detection System	2016	6,914		20	691	691	1,613	4
5	Tear Off And Replacement Of North And West Canopies	2017	5,650		20	283	283	447	5
6	Accutech - Resident Guard Wander Mgmt System Door Kit	2017	3,317		20	166	166	249	6
7	Rising Development - Roof Repairs	2017	51,400		20	2,570	2,570	2,998	7
8	Generator Project	2018	139,260		20	6,383	6,383	6,383	8
9	Heavy Duty Safety Bollard	2018	2,580		20	97	97	97	9
10	State Water Heater	2018	20,698		20	690	690	690	10
11	Concrete Repairs	2018	14,850		20	743	743	743	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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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)		$ 2,626,231	$ 183,911		$ 64,362	$ (119,549)	$ 1,947,041	34

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$ 2,626,231	$ 183,911		$ 64,362	$ (119,549)	$ 1,947,041	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,626,231	$ 183,911		$ 64,362	$ (119,549)	$ 1,947,041	34

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,626,231	$ 183,911		$ 64,362	$ (119,549)	$ 1,947,041	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
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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)		$ 2,626,231	$ 183,911		$ 64,362	$ (119,549)	$ 1,947,041	34

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 12D, Carried Forward		$ 2,626,231	$ 183,911		$ 64,362	$ (119,549)	$ 1,947,041	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,626,231	$ 183,911		$ 64,362	$ (119,549)	$ 1,947,041	34

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 12F, Carried Forward		$	$		$	$	$	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									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$	$		$	$	$	34

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Double You Realty LLC	2003	120,233		35	3,083	3,083	49,200	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare Management	2016	6,541		20	327	327	872	9
10	Allocated from Staycare Management	2003	5,569		20	278	278	4,333	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	TOTAL (lines 1 thru 33)		$ 132,343	$		$ 3,688	$ 3,688	$ 54,405	34

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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 12H, Carried Forward		$ 132,343	$		$ 3,688	$ 3,688	$ 54,405	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
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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)		$ 132,343	$		$ 3,688	$ 3,688	$ 54,405	34

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 115,364	$	$ 10,639	$ 10,639	10	$ 89,640	71
72	Current Year Purchases	3,414		341	341	10	341	72
73	Fully Depreciated Assets	1,042,680				10	1,042,680	73
74								74
75	TOTALS	$ 1,161,458	$	$ 10,980	$ 10,980		$ 1,132,661	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		Alloc from Staycare Mgmt	2012	$ 8,514	$	$ 1,037	$ 1,037	5	$ 7,606	76
77										77
78										78
79										79
80	TOTALS			$ 8,514	$	$ 1,037	$ 1,037		$ 7,606	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)	$ 3,933,492	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 183,911	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 76,380	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (107,531)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,087,308	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		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Elevator Modernization	$ 22,080	92
93			93
94			94
95		$ 22,080	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.

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: *

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.	/2019	$
13.	/2020	$
14.	/2021	$

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	Allocated from Staycare Management		$	$ 9,926	17
18					18
19					19
20					20
21	TOTAL		$	$ 9,926	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.

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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
   - [X] NO

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 122,310	$		$ 122,310	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			38,890			38,890	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			145,240			145,240	4
5	Physician Care	39 - 03	visits			1,300			1,300	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				75,589		75,589	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 307,740	$ 75,589		$ 383,329	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.

STATE OF ILLINOIS

Facility Name & ID Number Atrium Health Care Center # 0033977 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/18 **(last day of reporting year)**

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	$ 867,134	$ 912,584	1
2	Cash-Patient Deposits	149,608	149,608	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,035,319	1,035,319	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	403,090	403,090	6
7	Other Prepaid Expenses	990	990	7
8	Accounts Receivable (owners or related parties)	61,536	61,536	8
9	Other(specify): See Attached Schedule	600	600	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,518,277	$ 2,563,727	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		260,000	13
14	Buildings, at Historical Cost		4,460,623	14
15	Leasehold Improvements, at Historical Cost	1,178,072	1,178,072	15
16	Equipment, at Historical Cost	384,118	864,118	16
17	Accumulated Depreciation (book methods)	(1,019,176)	(5,615,113)	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 Attached Schedule	1,014,369	22,080	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,557,383	$ 1,169,780	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,075,660	$ 3,733,507	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 432,116	$ 432,116	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	149,479	149,479	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	269,811	269,811	30
31	Accrued Taxes Payable (excluding real estate taxes)	386	386	31
32	Accrued Real Estate Taxes(Sch.IX-B)	244,000	244,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	125,191	125,191	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,220,983	$ 1,220,983	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		3,847,458	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 3,847,458	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,220,983	$ 5,068,441	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,854,677	$ (1,334,934)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,075,660	$ 3,733,507	48

***(See instructions.)**

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,398,228	1
2	Restatements (describe):		2
3		(13,942)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,384,286	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	470,391	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)**	$ 470,391	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)**	$ 2,854,677	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,116,047	1
2	Discounts and Allowances for all Levels	903,757	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,019,804	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	672,623	6
7	Oxygen	60	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 672,683	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		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	76,114	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,199	19
20	Radiology and X-Ray		20
21	Other Medical Services	6,829	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 86,142	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,652	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,652	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	4,772	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,772	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,808,053	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,390,567	31
32	Health Care	2,459,899	32
33	General Administration	2,088,490	33
	B. Capital Expense		
34	Ownership	2,608,376	34
	C. Ancillary Expense		
35	Special Cost Centers	383,329	35
36	Provider Participation Fee	407,001	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,337,662	40
41	**Income before Income Taxes (line 30 minus line 40)****	470,391	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 470,391	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 7,909,334	44
45	Private Pay - Net Inpatient Revenue	114,965	45
46	Medicare - Net Inpatient Revenue	903,757	46
47	Other-(specify) Veterans	91,748	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 9,019,804	49

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

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,716	4,188	$ 171,019	$ 40.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,275	9,021	293,707	32.56	3
4	Licensed Practical Nurses	22,223	25,025	692,056	27.65	4
5	CNAs & Orderlies	49,573	53,562	709,987	13.26	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,957	2,198	33,776	15.37	8
9	Activity Director	1,792	1,966	25,783	13.11	9
10	Activity Assistants	5,622	5,798	69,937	12.06	10
11	Social Service Workers	5,536	5,839	102,752	17.60	11
12	Dietician					12
13	Food Service Supervisor	1,790	1,852	33,537	18.11	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,513	20,438	265,919	13.01	15
16	Dishwashers					16
17	Maintenance Workers	4,811	5,407	105,446	19.50	17
18	Housekeepers	15,249	16,914	213,471	12.62	18
19	Laundry	5,355	6,021	79,077	13.13	19
20	Administrator	1,704	1,836	107,280	58.43	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,048	9,377	117,511	12.53	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	828	941	15,850	16.84	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	5,618	6,158	215,453	34.99	33
34	TOTAL (lines 1 - 33)	161,610	176,541	$ 3,252,561 *	$ 18.42	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 10,045	01-03	35
36	Medical Director	Monthly	24,050	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,466	10-03	39
40	Physical Therapy Consultant	72	3,499	10a-03	40
41	Occupational Therapy Consultant	13	664	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	6	293	10a-03	43
44	Activity Consultant	19	976	11-03	44
45	Social Service Consultant	33	1,845	12-03	45
46	Other(specify)				46
47	Religious Services	Monthly	3,750	12-03	47
48	MDS Consulting	Monthly	12,000	10-03	48
49	TOTAL (lines 35 - 48)	144	$ 72,588		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Aharon Diena (thru 8/3/18)	Administrator	0	$ 77,576
Jason Lee (7/30/18-10/23/18)	Administrator	0	29,704
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,280

B. Administrative - Other

Description	Amount
Staycare Management - Management Fees	$ 555,250
TOTAL (agree to Schedule V, line 17, col. 3)	$ 555,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting	$ 19,620
Staycare Management	Other Professional Fees	3,735
Stout	Appraisal (Adjusted page 5)	5,004
See Attached	Legal	47,875
KBC Computer	Computer Services	4,341
Personnel Planners	Unemployment Consultant	1,200
Staycare Management	Reimbursement Consultant	26,555
Staycare Management	Outside Office Labor	26,360
Cukerski & Cochrane	Accounting	929
Sigmacare	E-Charting	10,901
Matrixcare	E-Charting	21,803
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 168,323

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,518
Unemployment Compensation Insurance	21,220
FICA Taxes	241,983
Employee Health Insurance	137,523
Employee Meals	44,895
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	604
Union Pension Expense	27,046
401K Employer	348
Holiday Expense	3,320
TOTAL (agree to Schedule V, line 22, col.8)	$ 542,457

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,400
Advertising: Employee Recruitment	983
Health Care Worker Background Check	2,745
(Indicate # of checks performed 275)	
Patient Background Checks	
Dues & Subscriptions	19,040
Licenses, Permits & Fees	4,745
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,913

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,384
Allocated from Staycare Management	388
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,772

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/18 Ending: 12/31/18

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **HCCI $17,280**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(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? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **23,519** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **407,001**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** 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. $ **44,895** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
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? **No**
Firm Name: **N/A**

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.