



Facility Name & ID Number Atrium Health Care Center

# 0033977 Report Period Beginning: 01/01/16 Ending: 12/31/16

**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 \_\_\_\_\_**

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,560	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	58,560	7

**B. Census-For the entire report period.**

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		2 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,634		2,582	11,216	8
9	SNF/PED					9
10	ICF	40,443			40,443	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,077		2,582	51,659	14

**C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.22%**

**D. How many bed-hold days during this year were paid by the Department?**  
None (Do not include bed-hold days in Section B.)

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

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

**I. On what date did you start providing long term care at this location?**  
Date started 07/01/1988

**J. Was the facility purchased or leased after January 1, 1978?**  
YES  Date 07/01/1988 NO

**K. Was the facility certified for Medicare during the reporting year?**  
YES  NO  If YES, enter number of beds certified 116 and days of care provided 2,582

Medicare Intermediary Wisconsin Physician Services

**IV. ACCOUNTING BASIS**

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/13/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	258,927	61,905	9,872	330,704		330,704	13,609	344,313		1
2	Food Purchase		248,139		248,139	(40,216)	207,923		207,923		2
3	Housekeeping	186,243	35,552		221,795		221,795		221,795		3
4	Laundry	62,727	18,166		80,893		80,893		80,893		4
5	Heat and Other Utilities			143,899	143,899		143,899	(4,167)	139,732		5
6	Maintenance	96,024	23,694	62,709	182,427		182,427	3,732	186,159		6
7	Other (specify):*							1,847	1,847		7
8	<b>TOTAL General Services</b>	<b>603,921</b>	<b>387,456</b>	<b>216,480</b>	<b>1,207,857</b>	<b>(40,216)</b>	<b>1,167,641</b>	<b>15,021</b>	<b>1,182,662</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			21,750	21,750		21,750		21,750		9
10	Nursing and Medical Records	1,757,553	56,387	29,425	1,843,365		1,843,365		1,843,365		10
10a	Therapy	27,940		3,750	31,690		31,690		31,690		10a
11	Activities	84,081	1,755	988	86,824		86,824		86,824		11
12	Social Services	116,217		4,823	121,040		121,040		121,040		12
13	CNA Training										13
14	Program Transportation			513	513		513		513		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,985,791</b>	<b>58,142</b>	<b>61,249</b>	<b>2,105,182</b>		<b>2,105,182</b>		<b>2,105,182</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	118,648		434,175	552,823		552,823	(328,510)	224,313		17
18	Directors Fees										18
19	Professional Services			115,310	115,310	(13,836)	101,474	(6,103)	95,371		19
20	Dues, Fees, Subscriptions & Promotions			38,493	38,493		38,493	(8,530)	29,963		20
21	Clerical & General Office Expenses	86,000	30,624	57,239	173,863		173,863	36,857	210,720		21
22	Employee Benefits & Payroll Taxes			445,259	445,259	40,216	485,475		485,475		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,235	1,235		1,235	256	1,491		24
25	Other Admin. Staff Transportation			1,051	1,051		1,051	5,152	6,203		25
26	Insurance-Prop.Liab.Malpractice			175,673	175,673		175,673	3,233	178,906		26
27	Other (specify):*							60,839	60,839		27
28	<b>TOTAL General Administration</b>	<b>204,648</b>	<b>30,624</b>	<b>1,268,435</b>	<b>1,503,707</b>	<b>26,380</b>	<b>1,530,087</b>	<b>(236,807)</b>	<b>1,293,280</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,794,360</b>	<b>476,222</b>	<b>1,546,164</b>	<b>4,816,746</b>	<b>(13,836)</b>	<b>4,802,910</b>	<b>(221,786)</b>	<b>4,581,124</b>		<b>29</b>

\*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.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			14,132	14,132		14,132	82,217	96,349		30
31	Amortization of Pre-Op. & Org.										31
32	Interest			2,151	2,151		2,151	159,105	161,256		32
33	Real Estate Taxes			200,728	200,728	13,836	214,564	6,228	220,792		33
34	Rent-Facility & Grounds			2,450,000	2,450,000		2,450,000	(2,450,000)			34
35	Rent-Equipment & Vehicles							6,791	6,791		35
36	Other (specify):*										36
37	<b>TOTAL Ownership</b>			2,667,011	2,667,011	13,836	2,680,847	(2,195,659)	485,188		37
	<b>Ancillary Expense</b>										
	<b>E. Special Cost Centers</b>										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers		105,580	267,022	372,602		372,602		372,602		39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			388,297	388,297		388,297		388,297		42
43	Other (specify):*										43
44	<b>TOTAL Special Cost Centers</b>		105,580	655,319	760,899		760,899		760,899		44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,794,360	581,802	4,868,494	8,244,656		8,244,656	(2,417,445)	5,827,211		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:

**01/01/16**

Ending:

**12/31/16**

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(6,083)	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	(89,513)	30		9
10	Interest and Other Investment Income	(2,240)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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	(20,437)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,002)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,178)	20		28
29	Other-Attach Schedule	(84,668)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (212,121)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	(2,205,324)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (2,205,324)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,417,445)		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

<b>BHF USE ONLY</b>							
48		49		50		51	52

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/16

Ending: 12/31/16

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (3,800)	21	1
2	MCA Sequester Reduction	(23,289)	21	2
3	Capitalized R&M	(4,484)	06	3
4	Building Co. - Accounting Fees	(1,325)	19	4
5	Building Co. - Illinois RT	(30,742)	21	5
6	Collections Expense	(1,132)	21	6
7	PAC Dues	(7,352)	20	7
8	Non-allowable legal fees	(12,544)	19	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(84,668)		49

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/16

Ending: 12/31/16

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	<b>Total</b>		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				13,609								13,609	1
2	Food Purchase													2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(6,083)		1,916									(4,167)	5
6	Maintenance	(4,484)		1,919	6,297								3,732	6
7	Other (specify):*				1,847								1,847	7
8	<b>TOTAL General Services</b>	<b>(10,567)</b>		<b>3,835</b>	<b>21,753</b>								<b>15,021</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(397,081)	68,571								(328,510)	17
18	Directors Fees													18
19	Professional Services	(13,869)	1,325	5,693		748							(6,103)	19
20	Fees, Subscriptions & Promotions	(8,530)											(8,530)	20
21	Clerical & General Office Expenses	(87,402)	30,742	93,517									36,857	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			256									256	24
25	Other Admin. Staff Transportation			5,152									5,152	25
26	Insurance-Prop.Liab.Malpractice			2,642		591							3,233	26
27	Other (specify):*			56,489	4,350								60,839	27
28	<b>TOTAL General Administration</b>	<b>(109,801)</b>	<b>32,067</b>	<b>(233,332)</b>	<b>72,921</b>	<b>1,339</b>							<b>(236,807)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> (sum of lines 8,16 & 28)	<b>(120,368)</b>	<b>32,067</b>	<b>(229,497)</b>	<b>94,674</b>	<b>1,339</b>							<b>(221,786)</b>	<b>29</b>

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I		
30	Depreciation	(89,513)	162,204	6,615		2,911							82,217	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,240)	159,225	37		2,083							159,105	32
33	Real Estate Taxes					6,228							6,228	33
34	Rent-Facility & Grounds		(2,450,000)	17,529		(17,529)							(2,450,000)	34
35	Rent-Equipment & Vehicles			6,791									6,791	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	<b>(91,753)</b>	<b>(2,128,571)</b>	<b>30,972</b>		<b>(6,307)</b>							<b>(2,195,659)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>													<b>44</b>
45	<b>GRAND TOTAL COST (sum of lines 29, 37 &amp; 44)</b>	<b>(212,121)</b>	<b>(2,096,504)</b>	<b>(198,525)</b>	<b>94,674</b>	<b>(4,969)</b>							<b>(2,417,445)</b>	<b>45</b>

**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.**  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 2,450,000	Atrium Healthcare Center Ltd. Partnership	100.00%	\$	\$ (2,450,000)	1
2	V	19 Accounting Fees		Atrium Healthcare Center Ltd. Partnership	100.00%	1,325	1,325	2
3	V	32 Mortgage Interest		Atrium Healthcare Center Ltd. Partnership	100.00%	159,225	159,225	3
4	V	30 Depreciation		Atrium Healthcare Center Ltd. Partnership	100.00%	162,204	162,204	4
5	V	21 Illinois RT		Atrium Healthcare Center Ltd. Partnership	100.00%	30,742	30,742	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		\$ 2,450,000			\$ 353,496	\$ * (2,096,504)	14

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 1,916	\$ 1,916
16	V	6 REPAIRS AND MAINT.				1,919	1,919
17	V	17 ADMIN. SALARY				37,094	37,094
18	V	19 PROFESSIONAL FEES				5,693	5,693
19	V	20 DUES, SUBSCRIPTIONS					
20	V	21 CLERICAL & GENERAL				93,517	93,517
21	V	24 SEMINARS				256	256
22	V	25 ADMIN. STAFF TRAVEL				5,152	5,152
23	V	26 INSURANCE				2,642	2,642
24	V	27 EMPLOYEE BENEFITS				56,489	56,489
25	V	30 DEPRECIATION				6,615	6,615
26	V	32 INTEREST EXPENSE				37	37
27	V	34 BUILDING RENT				17,529	17,529
28	V	35 EQUIP. RENTAL-AUTO				6,791	6,791
29	V						
30	V	17 Management Fees	434,175	STAYCARE MANAGEMENT, LTD.			(434,175)
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 434,175			\$ 235,650	\$ * (198,525)

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 3,429	\$	3,429	15
16	V	1 DIET. COMP - D. WENGROW				10,180		10,180	16
17	V	6 MAINT. COMP.				6,297		6,297	17
18	V	7 EMP. BEN. - S. WEBSTER				316		316	18
19	V	7 EMP. BEN. - D. WENGROW				861		861	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER				670		670	20
21	V	17 ADMIN. COMP - H. WENGROW				13,702		13,702	21
22	V	17 ADMIN. COMP - J. WEBSTER				54,869		54,869	22
23	V	27 EMP. BEN. - H. WENGROW				908		908	23
24	V	27 EMP. BEN. - J. WEBSTER				3,442		3,442	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		\$			\$ 94,674	\$ *	94,674	39

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

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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$		100.00%	\$		15
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		392	392	16
17	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		591	591	17
18	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		2,911	2,911	18
19	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		2,083	2,083	19
20	V	19 RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		356	356	20
21	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		6,228	6,228	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	17,529	DOUBLE YOU REALTY, LLC			(17,529)	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		\$ 17,529			\$ 12,560	\$ * (4,969)	39

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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	<b>Total</b>		\$			\$	\$ *	39

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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	<b>Total</b>		\$			\$	\$ *	39

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
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	<b>Total</b>		\$			\$	\$ *	39

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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	<b>Total</b>		\$			\$	\$ *	39

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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	<b>Total</b>		\$			\$	\$ *	39

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

**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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
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	<b>Total</b>		\$			\$	\$ *	39

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

Facility Name &amp; ID Number

Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

## 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	.6250%	ABBINGTON REHAB & NURSING CENTER, LTD.	ROSELLE	ATRIUM HEALTHCARE LTD. P.	LINCOLNWOOD	BUILDING CO.	1
2	ABRAHAM STERN	3.1250%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING CO.	2
3	ARTHUR ROTHBLATT	.42180%	HICKORY NURSING PAVILION, INC.	HICKORY HILLS	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKKEE	3
4	BERNARD FRUCHTER	.38810%	RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				4
5	BETTE COHEN	.20850%	ZIKAINIM, INC. D/B/A ALL AMERICAN NURSING HOME	CHICAGO				5
6	CARY BUXBAUM	.42180%						6
7	DAVID WENGROW	1.25%						7
8	DINA BRAUNSTEIN	1.25%						8
9	EDWARD G ROTHBLATT ADMIN TRU	.4219%						9
10	ELI WEBSTER	1.25%						10
11	GAIL GOODSITE REVOCABLE TRUST	.38810%						11
12	GARRY CHANKIN	.2109%						12
13	HOWARD WENGROW	30.93700%						13
14	JAY WENGROW	1.25%						14
15	JEFFREY J. WEBSTER	29.68800%						15
16	JEFFREY SINGER	.42180%						16
17	MARVIN FOX	.42180%						17
18	MYRNA HILL	.42180%						18
19	NOSHIR DARUWALLA	.42180%						19
20	RICHARD SGARLATA	.42180%						20
21	ROBERT A. ROSE	.42180%						21
22	SHERRY WARSO	18.75%						22
23	SHIMON WEBSTER	1.25%						23
24	STEVE SILBERMAN	.42180%						24
25	SUSAN STERN	3.13%						25
26	YAAKOV MIKEL	.6250%						26
27	YERUCHOM LEVOVITZ	1.25%						27
28	JANET CHANKIN	.2109%						28
29								29
30								30

Facility Name & ID Number

Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending:

12/31/16

**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 &amp; ID Number

Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending:

12/31/16

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference		
						Hours	Percent	Description	Amount			
1	Jeffrey Webster	Owner	Administrative	29.69%	See Attached	20	28.57%	Alloc. Salary	\$ 54,869	17-07	1	
2	Howard Wengrow	Owner	Administrative	30.94%	See Attached	5	7.69%	Alloc. Salary	13,702	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	9.5	23.75%	Alloc. Salary	18,496	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	\$ 100,676		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:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	217,497	6	\$ 8,067	\$ 51,659	\$ 1,916	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	217,497	6	8,079	51,659	1,919	2	
3	17	ADMIN. SALARY	PATIENT DAYS	217,497	6	156,174	156,174	51,659	37,094	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	217,497	6	23,970	51,659	5,693	4	
5	21	CLERICAL & GENERAL	PATIENT DAYS	217,497	6	393,729	339,385	51,659	93,517	5
6	24	SEMINARS	PATIENT DAYS	217,497	6	1,079	51,659	256	6	
7	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	217,497	6	21,689	51,659	5,152	7	
8	26	INSURANCE	PATIENT DAYS	217,497	6	11,124	51,659	2,642	8	
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	217,497	6	237,834	51,659	56,489	9	
10	30	DEPRECIATION	PATIENT DAYS	217,497	6	27,851	51,659	6,615	10	
11	32	INTEREST	PATIENT DAYS	217,497	6	155	51,659	37	11	
12	34	BUILDING RENT	PATIENT DAYS	217,497	6	73,800	51,659	17,529	12	
13	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	217,497	6	28,591	51,659	6,791	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					\$ 992,142	\$ 495,559	\$ 235,650	25	

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	2	3,429	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	2	10,180	2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	10	6,297	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	932	2	316	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,537	2	861	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,822	10	670	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	178,120	5	13,702	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	192,042	20	54,869	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	11,798	5	908	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,046	20	3,442	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					\$ 466,911	\$ 436,776	\$ 94,674	25

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

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 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	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	217,497	6	1,650	51,659	392	2
3	26	INSURANCE	PATIENT DAYS	217,497	6	2,487	51,659	591	3
4	30	DEPRECIATION	PATIENT DAYS	217,497	6	12,254	51,659	2,911	4
5	32	INTEREST EXPENSE	PATIENT DAYS	217,497	6	8,771	51,659	2,083	5
6	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	217,497	6	1,500	51,659	356	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	217,497	6	26,220	51,659	6,228	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				\$	52,882	\$	12,560	25

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending: 12/31/16

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

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

Facility Name & ID Number

Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/16

Ending:

12/31/16

**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	Name of Lender	2		3	4	5	6		7	8	9	10						
		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			
<b>A. Directly Facility Related</b>																		
<b>Long-Term</b>																		
1	MB Financial		X	Mortgage	41,146		\$ 5,937,163	\$ 4,301,925			\$ 159,225	1						
2	Allocated from Double You		X	Mortgage							2,083	2						
3	Allocated from Staycare										37	3						
4												4						
5					-							5						
<b>Working Capital</b>																		
6	MB Financial		X	Loan Payable				38,010			2,151	6						
7												7						
8					-							8						
9	<b>TOTAL Facility Related</b>				41146.00		\$ 5,937,163	\$ 4,339,935			\$ 163,496	9						
<b>B. Non-Facility Related*</b>																		
10	Interest Income		X								(2,240)	10						
11												11						
12												12						
13					-							13						
14	<b>TOTAL Non-Facility Related</b>						\$	\$			\$ (2,240)	14						
15	<b>TOTALS (line 9+line14)</b>						\$ 5,937,163	\$ 4,339,935			\$ 161,256	15						

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

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

\*\* 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:

01/01/16

Ending:

12/31/16

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**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			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1							\$	\$		\$	1									
2											2									
3											3									
4											4									
5											5									
6											6									
7	<b>TOTAL Long-Term</b>										7									
<b>Working Capital</b>																				
8							\$	\$		\$	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	<b>TOTAL Working Capital</b>										14									
<b>B. Non-Facility Related*</b>																				
15							\$	\$		\$	15									
16											16									
17											17									
18											18									
19											19									
20	<b>TOTAL Non-Facility Related</b>										20									

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)



**2015 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 Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-32-105-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,307.42</u>	\$ <u>3,307.42</u>
2. <u>11-32-105-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>49,851.12</u>	\$ <u>49,851.12</u>
3. <u>11-32-105-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>95,222.97</u>	\$ <u>95,222.97</u>
4. <u>11-32-105-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>49,523.29</u>	\$ <u>49,523.29</u>
5. <u>10-35-329-014-0000</u>	<u>Home Office</u>	\$ <u>26,219.28</u>	\$ <u>6,227.50</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
	<b>TOTALS</b>	\$ <u><u>224,124.08</u></u>	\$ <u><u>204,132.30</u></u>

**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? X 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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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: 2015 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 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 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.

**2015 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 Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

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

Enter the tax index number and real estate tax assessed for 2015 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 2015.

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

**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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

**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:

01/01/16 Ending:

12/31/16

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 (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

Blank lines for listing other business entities.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

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

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

XI. OWNERSHIP COSTS:

A. Land.

Table with 5 columns: Use, Square Feet, Year Acquired, Cost, and a final column with values 1, 2, 3. Rows include Facility, Allocated from Double You, and TOTALS.

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	160		1972	\$ 574,854	\$ 162,204	33	\$	(162,204)	\$ 919,825	4
5			1972	344,971		20				5
6										6
7										7
8										8
<b>Improvement Type**</b>										
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	864	864	70,977	21
22	Various		1997	52,684		20	2,629	2,629	51,745	22
23	Various		1998	131,108		20	6,555	6,555	122,248	23
24	Various		1999	9,413		20	471	471	8,174	24
25	Various		2000	67,328		20	1,670	1,670	40,575	25
26	Various		2001	13,010		20	651	651	10,200	26
27	Various		2002	5,102		20			5,102	27
28	Various		2003	55,595		20	1,113	1,113	51,150	28
29	Various		2004	7,347		20	223	223	5,709	29
30	Various		2005	15,308		20	141	141	14,076	30
31	Various		2006	47,619		20	2,317	2,317	44,900	31
32	Various		2007	6,765		20	338	338	3,354	32
33	Various		2008	48,015		20	2,202	2,202	41,563	33
34	Various		2009	87,312		20	8,731	8,731	66,681	34
35	Various		2010	52,946		20	5,009	5,009	32,178	35
36	Various		2011	25,166		20	2,759	2,759	16,558	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 Various	2012	\$ 148,718	\$	20	\$ 21,906	\$ 21,906	\$ 101,182	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
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)		124,950	9,086		3,380	(5,706)	44,400	68
69 Financial Statement Depreciation			14,132			(14,132)		69
70 TOTAL (lines 4 thru 69)		\$ 2,169,542	\$ 185,422		\$ 60,959	\$ (124,463)	\$ 1,761,616	70

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

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 2,169,542	\$ 185,422		\$ 60,959	\$ (124,463)	\$ 1,761,616	1
2	Chiller	2013	120,583		20	12,058	12,058	43,209	2
3	Walk-In Cooler Repair	2013	2,818		20	141	141	564	3
4	Sprinkler System - Replace Hose, Relief & Butterfly Valve	2014	3,150		20	158	158	407	4
5	Controls & Parts To Install Fire Pump Annunciator	2014	2,716		20	136	136	351	5
6	Lintel Replacement / Tuckpointing	2014	34,944		20	1,747	1,747	3,640	6
7	Walk In Cooler	2015	2,516		20	252	252	398	7
8	Tuckpointing	2016	37,900		20	1,895	1,895	1,895	8
9	Fire Detection System	2016	6,914		20	230	230	230	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	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,381,083	\$ 185,422		\$ 77,576	\$ (107,846)	\$ 1,812,310	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:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,381,083	\$ 185,422		\$ 77,576	\$ (107,846)	\$ 1,812,310	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		\$ 2,381,083	\$ 185,422		\$ 77,576	\$ (107,846)	\$ 1,812,310	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,381,083	\$ 185,422		\$ 77,576	\$ (107,846)	\$ 1,812,310	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		\$ 2,381,083	\$ 185,422		\$ 77,576	\$ (107,846)	\$ 1,812,310	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:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,381,083	\$ 185,422		\$ 77,576	\$ (107,846)	\$ 1,812,310	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		\$ 2,381,083	\$ 185,422		\$ 77,576	\$ (107,846)	\$ 1,812,310	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1 Building Company		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8 Leasehold Improvements:							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34 TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1		\$	\$		\$	\$	\$
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34		\$	\$		\$	\$	\$

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You	2003	113,517	2,911	20	2,911		40,629	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare	2003	5,258		20	263	263	3,565	9
10	Allocated from Staycare	2016	6,175	6,175	20	206	(5,969)	206	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)		\$ 124,950	\$ 9,086		\$ 3,380	\$ (5,706)	\$ 44,400	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:

01/01/16

Ending:

12/31/16

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 124,950	\$ 9,086		\$ 3,380	\$ (5,706)	\$ 44,400	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		\$ 124,950	\$ 9,086		\$ 3,380	\$ (5,706)	\$ 44,400	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:

01/01/16

Ending:

12/31/16

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	\$ 138,706	\$	\$ 17,346	\$ 17,346	10	\$ 103,121	71
72	Current Year Purchases	4,484		448	448	10	448	72
73	Fully Depreciated Assets	1,002,530				10	1,002,530	73
74								74
75	TOTALS	\$ 1,145,720	\$	\$ 17,794	\$ 17,794		\$ 1,106,099	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		Allocated from Staycare Manager	2012	\$ 8,038	\$ 440	\$ 979	\$ 539	5	\$ 5,223	76
77										77
78										78
79										79
80	TOTALS			\$ 8,038	\$ 440	\$ 979	\$ 539		\$ 5,223	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)	\$ 3,671,429	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 185,862	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 96,349	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (89,513)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,923,631	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		\$	92
93			93
94			94
95		\$	95

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

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

**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	<b>TOTAL</b>				\$			7

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

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

	Fiscal Year Ending	Annual Rent
--	--------------------	-------------

12. \_\_\_\_\_ /2017 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2018 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2019 \$ \_\_\_\_\_

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_ \*

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

15. Is Movable equipment rental included in building rental?

YES  NO

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

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Staycare		\$	\$ 6,791	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$ -	\$ 6,791	21

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	<b>TOTALS</b>	\$	\$	\$	\$
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)	
<b>TOTAL TRAINED</b>	

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3	4		5	6	7	8	
			Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service			Units	Cost					
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	107,902	\$		\$	107,902	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				45,536				45,536	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				113,584				113,584	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					105,580			105,580	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): <u>See Supplemental</u>											13
14	TOTAL			\$		\$	267,022	\$	105,580	\$	372,602	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.

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning: 01/01/16

Ending:

12/31/16

**XV. BALANCE SHEET - Unrestricted Operating Fund.**

As of 12/31/16

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 412,674	\$ 443,874	1
2	Cash-Patient Deposits	121,915	121,915	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,404,494	2,404,494	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	244,834	244,834	6
7	Other Prepaid Expenses	993	993	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,184,910	\$ 3,216,110	10
	<b>B. Long-Term Assets</b>			
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	957,747	957,747	15
16	Equipment, at Historical Cost	373,209	853,209	16
17	Accumulated Depreciation (book methods)	(962,303)	(5,233,832)	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):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 368,653	\$ 1,297,747	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,553,563	\$ 4,513,857	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 303,503	\$ 303,503	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	121,787	121,787	28
29	Short-Term Notes Payable	38,010	38,010	29
30	Accrued Salaries Payable	205,022	205,022	30
31	Accrued Taxes Payable (excluding real estate taxes)	551	551	31
32	Accrued Real Estate Taxes(Sch.IX-B)	207,800	207,800	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule</u>	162,390	162,390	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,039,063	\$ 1,039,063	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,301,925	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>See Attached Schedule</u>	566,599		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 566,599	\$ 4,301,925	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,605,662	\$ 5,340,988	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 1,947,901	\$ (827,131)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,553,563	\$ 4,513,857	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>864,748</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	Prior Year Adj-Bad Debt, Distributions and Rounding	<b>574,553</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>1,439,301</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>508,600</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>508,600</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>1,947,901</b>	<b>24</b> *

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

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

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

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

1			
I. Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,098,315	1
2	Discounts and Allowances for all Levels	904,606	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 8,002,921	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	621,710	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 621,710	8
<b>C. Other Operating Revenue</b>			
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	101,963	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,206	19
20	Radiology and X-Ray		20
21	Other Medical Services	8,130	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 113,299	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	2,240	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 2,240	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	13,086	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,086	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 8,753,256	30

2			
II. Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,207,857	31
32	Health Care	2,105,182	32
33	General Administration	1,503,707	33
<b>B. Capital Expense</b>			
34	Ownership	2,667,011	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	372,602	35
36	Provider Participation Fee	388,297	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 8,244,656	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	508,600	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 508,600	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,098,315	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue	904,606	46
47	Other-(specify)		47
48	Other-(specify)		48
49	<b>TOTAL Inpatient Care Revenue (This total must agree to Line 3)</b>	\$ 8,002,921	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: **01/01/16**

Ending:

**12/31/16**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,832	4,264	\$ 166,471	\$ 39.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,897	7,631	234,138	30.68	3
4	Licensed Practical Nurses	23,992	26,510	613,351	23.14	4
5	CNAs & Orderlies	44,948	51,436	539,472	10.49	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,930	2,174	27,940	12.85	8
9	Activity Director	1,803	1,987	24,810	12.49	9
10	Activity Assistants	5,365	5,620	59,271	10.55	10
11	Social Service Workers	5,977	6,358	116,217	18.28	11
12	Dietician					12
13	Food Service Supervisor	1,877	2,151	36,844	17.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,224	19,941	222,083	11.14	15
16	Dishwashers					16
17	Maintenance Workers	4,694	5,350	96,024	17.95	17
18	Housekeepers	15,990	17,662	186,243	10.54	18
19	Laundry	5,180	5,770	62,727	10.87	19
20	Administrator	2,424	2,634	118,648	45.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,815	7,346	86,000	11.71	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	800	950	15,775	16.61	31
32	Other Health Care(specify)					32
33	Other(specify)	5,317	5,746	188,346	32.78	33
34	TOTAL (lines 1 - 33)	156,065	173,530	\$ 2,794,360 *	\$ 16.10	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 9,872	01-03	35
36	Medical Director	Monthly	21,750	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	11,425	10-03	39
40	Physical Therapy Consultant	48	2,344	10a-03	40
41	Occupational Therapy Consultant	23	1,168	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	238	10a-03	43
44	Activity Consultant	19	988	11-03	44
45	Social Service Consultant	23	1,273	12-03	45
46	Other(specify)				46
47	Religious Services	Monthly	3,550	12-03	47
48	MDS Consulting	Monthly	18,000	10-03	48
49	TOTAL (lines 35 - 48)	118	\$ 70,608		49

**C. CONTRACT NURSES**

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



Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/16

Ending:

12/31/16**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. ILCLTC - \$22,280
- (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. \$ 24,271 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. \$ 388,297  
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. \$ 40,216 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (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% L14  
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 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