

Facility Name & ID Number Atrium Health Care Center

0033977 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	9,449	110	2,755	12,314	8
9	SNF/PED					9
10	ICF	41,073	51	333	41,457	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,522	161	3,088	53,771	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.07%

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

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 2,713

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: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/17 Ending: 12/31/17

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	277,879	69,938	9,936	357,753		357,753	13,609	371,362		1
2	Food Purchase		255,824		255,824	(39,807)	216,017	(8)	216,009		2
3	Housekeeping	201,160	34,408		235,568		235,568		235,568		3
4	Laundry	66,433	17,588		84,021		84,021		84,021		4
5	Heat and Other Utilities			148,147	148,147		148,147	(6,258)	141,889		5
6	Maintenance	96,526	34,320	53,459	184,305		184,305	11,740	196,045		6
7	Other (specify):*							1,878	1,878		7
8	TOTAL General Services	641,998	412,078	211,542	1,265,618	(39,807)	1,225,811	20,961	1,246,772		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	2,074,834	56,859	32,139	2,163,832		2,163,832	(805)	2,163,027		10
10a	Therapy	29,667		3,252	32,919		32,919		32,919		10a
11	Activities	85,576	3,418	630	89,624		89,624		89,624		11
12	Social Services	145,475		6,685	152,160		152,160		152,160		12
13	CNA Training										13
14	Program Transportation			901	901		901		901		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,335,552	60,277	67,607	2,463,436		2,463,436	(805)	2,462,631		16
	C. General Administration										
17	Administrative	111,943		517,175	629,118		629,118	(405,556)	223,562		17
18	Directors Fees										18
19	Professional Services			213,005	213,005	(190)	212,815	(78,366)	134,449		19
20	Dues, Fees, Subscriptions & Promotions			33,395	33,395		33,395	(9,846)	23,549		20
21	Clerical & General Office Expenses	117,896	30,364	211,686	359,946		359,946	(103,687)	256,259		21
22	Employee Benefits & Payroll Taxes			465,179	465,179	39,807	504,986		504,986		22
23	Inservice Training & Education										23
24	Travel and Seminar			750	750		750	209	959		24
25	Other Admin. Staff Transportation			4,423	4,423		4,423	6,484	10,907		25
26	Insurance-Prop.Liab.Malpractice			272,043	272,043		272,043	3,613	275,656		26
27	Other (specify):*							71,877	71,877		27
28	TOTAL General Administration	229,839	30,364	1,717,656	1,977,859	39,617	2,017,476	(515,272)	1,502,205		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,207,389	502,719	1,996,805	5,706,913	(190)	5,706,723	(495,116)	5,211,608		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:

01/01/17

Ending:

12/31/17

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost 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	
	D. Ownership											
30	Depreciation			35,166	35,166		35,166	50,046	85,212			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,279	12,279		12,279	172,778	185,057			32
33	Real Estate Taxes			235,374	235,374	190	235,564	9,348	244,912			33
34	Rent-Facility & Grounds			2,050,000	2,050,000		2,050,000	(2,050,000)				34
35	Rent-Equipment & Vehicles							7,288	7,288			35
36	Other (specify):*											36
37	TOTAL Ownership			2,332,819	2,332,819	190	2,333,009	(1,810,540)	522,469			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,615	342,759	435,374		435,374		435,374			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			396,590	396,590		396,590		396,590			42
43	Other (specify):*			1,120	1,120		1,120	(1,120)				43
44	TOTAL Special Cost Centers		92,615	740,469	833,084		833,084	(1,120)	831,964			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,207,389	595,334	5,070,093	8,872,816	(0)	8,872,816	(2,306,776)	6,566,040			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,130)	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	(115,736)	30		9
10	Interest and Other Investment Income	(6,598)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	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	(181,830)	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	(1,206)	20		28
29	Other-Attach Schedule	(167,063)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (480,571)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,826,205)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,826,205)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,306,776)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/17

Ending: 12/31/17

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (4,900)	21	1
2	Pharmacy - V.A.	(805)	10	2
3	Marketing Expense	(1,120)	43	3
4	MCA Sequester Reduction	(25,153)	21	4
5	Bldg Co. - Accounting Fees	(1,425)	19	5
6	Bldg Co. - Legal Fees	(7,206)	19	6
7	Bldg Co. - Illinois RT	(31,759)	21	7
8	Additional R&M	2,370	06	8
9	PAC Dues	(8,640)	20	9
10	Non-Allowable Legal Invoices	(85,438)	19	10
11	Capitalized R&M	(2,987)	06	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	(167,063)		49

Atrium Health Care Center

ID# 0033977
 Report Period Beginning: 01/01/17
 Ending: 12/31/17

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:

01/01/17

Ending:

12/31/17

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	(8)											(8)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(8,130)		1,872									(6,258)	5
6	Maintenance	(617)		5,521	6,836								11,740	6
7	Other (specify):*				1,878								1,878	7
8	TOTAL General Services	(8,755)		7,393	22,323								20,961	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(805)											(805)	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	(805)											(805)	16
	C. General Administration													
17	Administrative			(476,815)	71,259								(405,556)	17
18	Directors Fees													18
19	Professional Services	(94,069)	8,631	6,029		1,043							(78,366)	19
20	Fees, Subscriptions & Promotions	(9,846)											(9,846)	20
21	Clerical & General Office Expenses	(243,642)	31,759	108,196									(103,687)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			209									209	24
25	Other Admin. Staff Transportation			6,484									6,484	25
26	Insurance-Prop.Liab.Malpractice			2,953		660							3,613	26
27	Other (specify):*			67,363	4,514								71,877	27
28	TOTAL General Administration	(347,557)	40,390	(285,581)	75,773	1,703							(515,272)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(357,117)	40,390	(278,188)	98,096	1,703							(495,116)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	(115,736)	162,204	418		3,160							50,046	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(6,598)	177,305	9		2,062							172,778	32
33	Real Estate Taxes					9,348							9,348	33
34	Rent-Facility & Grounds		(2,050,000)	19,031		(19,031)							(2,050,000)	34
35	Rent-Equipment & Vehicles			7,288									7,288	35
36	Other (specify):*													36
37	TOTAL Ownership	(122,334)	(1,710,491)	26,746		(4,461)							(1,810,540)	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):*	(1,120)											(1,120)	43
44	TOTAL Special Cost Centers	(1,120)											(1,120)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(480,571)	(1,670,101)	(251,442)	98,096	(2,758)							(2,306,776)	45

Facility Name & ID Number

Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	\$ 2,050,000	Atrium Healthcare Center Ltd. Partnership	100.00%	\$	\$ (2,050,000)	1
2	V	19 Accounting Fees		Atrium Healthcare Center Ltd. Partnership	100.00%	1,425	1,425	2
3	V	19 Legal Fees		Atrium Healthcare Center Ltd. Partnership	100.00%	7,206	7,206	3
4	V	32 Mortgage Interest		Atrium Healthcare Center Ltd. Partnership	100.00%	177,305	177,305	4
5	V	30 Depreciation		Atrium Healthcare Center Ltd. Partnership	100.00%	162,204	162,204	5
6	V	21 Illinois RT		Atrium Healthcare Center Ltd. Partnership	100.00%	31,759	31,759	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,050,000			\$ 379,899	\$ * (1,670,101)	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%	\$ 1,872	\$ 1,872
16	V	6 REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.	100.00%	5,521	5,521
17	V	17 ADMIN. SALARY		STAYCARE MANAGEMENT, LTD.	100.00%	40,360	40,360
18	V	19 PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.	100.00%	6,029	6,029
19	V	21 CLERICAL & GENERAL - SALARIES		STAYCARE MANAGEMENT, LTD.	100.00%	93,663	93,663
20	V	21 CLERICAL & GENERAL - OTHER		STAYCARE MANAGEMENT, LTD.	100.00%	14,533	14,533
21	V	24 SEMINARS		STAYCARE MANAGEMENT, LTD.	100.00%	209	209
22	V	25 ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.	100.00%	6,484	6,484
23	V	26 INSURANCE		STAYCARE MANAGEMENT, LTD.	100.00%	2,953	2,953
24	V	27 EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.	100.00%	67,363	67,363
25	V	30 DEPRECIATION		STAYCARE MANAGEMENT, LTD.	100.00%	418	418
26	V	32 INTEREST		STAYCARE MANAGEMENT, LTD.	100.00%	9	9
27	V	34 BUILDING RENT		STAYCARE MANAGEMENT, LTD.	100.00%	19,031	19,031
28	V	35 EQUIP. RENTAL-AUTO		STAYCARE MANAGEMENT, LTD.	100.00%	7,288	7,288
29	V						
30	V	17 Management Fees	517,175	STAYCARE MANAGEMENT, LTD.	100.00%		(517,175)
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 517,175			\$ 265,733	\$ * (251,442)

* 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		STAY CARE MANAGEMENT, LTD.	100.00%	10,180		10,180	16
17	V	6 MAINT. COMP.		STAY CARE MANAGEMENT, LTD.	100.00%	6,836		6,836	17
18	V	7 EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	315		315	18
19	V	7 EMP. BEN. - D. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	856		856	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.	100.00%	707		707	20
21	V	17 ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	14,245		14,245	21
22	V	17 ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	57,014		57,014	22
23	V	27 EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.	100.00%	942		942	23
24	V	27 EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.	100.00%	3,572		3,572	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		\$			\$ 98,096	\$ *	98,096	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	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	854	\$	854	15
16	V	26 INSURANCE		DOUBLE YOU REALTY, LLC	100.00%	660		660	16
17	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC	100.00%	3,160		3,160	17
18	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC	100.00%	2,062		2,062	18
19	V	19 RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC	100.00%	189		189	19
20	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC	100.00%	9,348		9,348	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	19,031	DOUBLE YOU REALTY, LLC	100.00%			(19,031)	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		\$ 19,031			\$ 16,273	\$ *	(2,758)	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	Total		\$			\$	\$ *	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	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:

01/01/17

Ending:

12/31/17

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	\$ 57,014	17-07	1	
2	Howard Wengrow	Owner	Administrative	30.94%	See Attached	5	7.69%	Alloc. Salary	14,245	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	10.32	25.80%	Alloc. Salary	22,072	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	\$ 106,940		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:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending: 12/31/17

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	5	UTILITIES	PATIENT DAYS	208,514	6	\$ 7,261	\$ 53,771	\$ 1,872	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	208,514	6	21,410	53,771	5,521	2
3	17	ADMIN. SALARY	PATIENT DAYS	208,514	6	156,508	156,508	40,360	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	208,514	6	23,378	53,771	6,029	4
5	21	CLERICAL & GENERAL - SAL	PATIENT DAYS	208,514	6	363,209	363,209	93,663	5
6	21	CLERICAL & GENERAL - OTH	PATIENT DAYS	208,514	6	56,356	53,771	14,533	6
7	24	SEMINARS	PATIENT DAYS	208,514	6	810	53,771	209	7
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	208,514	6	25,144	53,771	6,484	8
9	26	INSURANCE	PATIENT DAYS	208,514	6	11,450	53,771	2,953	9
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	208,514	6	261,220	53,771	67,363	10
11	30	DEPRECIATION	PATIENT DAYS	208,514	6	1,621	53,771	418	11
12	32	INTEREST	PATIENT DAYS	208,514	6	34	53,771	9	12
13	34	BUILDING RENT	PATIENT DAYS	208,514	6	73,800	53,771	19,031	13
14	35	EQUIP. RENTAL-AUTO	PATIENT DAYS	208,514	6	28,262	53,771	7,288	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 1,030,464	\$ 519,717	\$ 265,733	25

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending: 12/31/17

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	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	10,104	2	3,429	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000	2	10,180	2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	10	6,836	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	928		2	315	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	2,524		2	856	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,741		10	707	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	185,182	185,182	5	14,245	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	199,550	199,550	20	57,014	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,252		5	942	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,502		20	3,572	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					\$ 482,293	\$ 451,346		\$ 98,096	25

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending: 12/31/17

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	19	PROFESSIONAL FEES	PATIENT DAYS	208,514	6	3,310	53,771	854	1
2	26	INSURANCE	PATIENT DAYS	208,514	6	2,559	53,771	660	2
3	30	DEPRECIATION	PATIENT DAYS	208,514	6	12,254	53,771	3,160	3
4	32	INTEREST EXPENSE	PATIENT DAYS	208,514	6	7,994	53,771	2,062	4
5	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	208,514	6	735	53,771	189	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	208,514	6	36,251	53,771	9,348	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					\$ 63,103	\$	\$ 16,273	25

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____

Fax Number (_____

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Atrium Health Care Center

0033977 Report Period Beginning: 01/01/17 Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending: 12/31/17

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number

Atrium Health Care Center

0033977

Report Period Beginning:

01/01/17

Ending:

12/31/17

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	\$41,146.00		\$ 5,937,163	\$ 4,042,387		\$ 177,305	1									
2											2									
3											3									
4											4									
5											5									
Working Capital																				
6	MB Financial		X	Loan Payable				9,675		12,279	6									
7											7									
8											8									
9	TOTAL Facility Related				\$41,146.00		\$ 5,937,163	\$ 4,052,062		\$ 189,584	9									
B. Non-Facility Related*																				
10	Interest Income		X							(6,598)	10									
11	Allocated from Double You									2,062	11									
12	Allocated from Staycare									9	12									
13											13									
14	TOTAL Non-Facility Related						\$	\$		\$ (4,527)	14									
15	TOTALS (line 9+line14)						\$ 5,937,163	\$ 4,052,062		\$ 185,057	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.)

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

B. Real Estate Taxes

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

1. Real Estate Tax accrual used on 2016 report.	\$	<u>208,063</u>	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.)	\$	<u>225,659</u>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<u>17,596</u>	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<u>108,155</u>	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.)	\$	<u>190</u>	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 \$ <u>570</u> For <u>###</u> 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.	\$	<u>125,940</u>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2012	<u>188,806</u>	8
	2013	<u>191,361</u>	9
	2014	<u>195,217</u>	10
	2015	<u>197,905</u>	11
	2016	<u>216,311</u>	12

Due to prepayments of \$118,971, Line 7 (above) and Page 4 Line 33 do not match.

2017 Accrual = \$216,311 x 1.05 - Prepayments = \$108,419

Allocated from Double You Realty: \$9,348

***Beginning Accrual Adjusted**

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2016	\$	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.

Facility Name & ID Number Atrium Health Care Center

0033977 Report Period Beginning:

01/01/17 Ending:

12/31/17

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).

None

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

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

Nature of Costs:

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

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	26,985	1975	\$ 124,712	1
2	Allocated from Double You			12,894	2
3	TOTALS	26,985		\$ 137,606	3

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						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			31,832	20
21	Various			1996	71,604		20			70,978	21
22	Various			1997	52,684		20	938	938	52,682	22
23	Various			1998	131,108		20	6,557	6,557	128,802	23
24	Various			1999	9,413		20	472	472	8,644	24
25	Various			2000	67,328		20	1,669	1,669	42,245	25
26	Various			2001	13,010		20	652	652	10,850	26
27	Various			2002	5,102		20			5,102	27
28	Various			2003	55,594		20	1,113	1,113	52,263	28
29	Various			2004	7,348		20	224	224	5,932	29
30	Various			2005	15,308		20	141	141	14,217	30
31	Various			2006	47,619		20	281	281	45,182	31
32	Various			2007	6,765		20	338	338	3,693	32
33	Various			2008	48,016		20	2,202	2,202	43,764	33
34	Various			2009	87,312		20	8,732	8,732	75,412	34
35	Various			2010	52,946		20	5,011	5,011	37,187	35
36	Various			2011	25,166		20	1,961	1,961	18,520	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	\$ 14,121	\$ 14,121	\$ 115,302	37
38 Various	2013	123,401		20	12,199	12,199	55,972	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)		135,662	3,160		3,780	620	51,989	68
69 Financial Statement Depreciation			35,166			(35,166)		69
70 TOTAL (lines 4 thru 69)		\$ 2,303,656	\$ 200,530		\$ 60,391	\$ (140,139)	\$ 1,869,580	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	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		\$ 2,303,656	\$ 200,530		\$ 60,391	\$ (140,139)	\$ 1,869,580	1
2	Sprinkler System - Replace Hose, Relief & Butterfly Valve	2014	3,150		20	158	158	564	2
3	Controls & Parts To Install Fire Pump Annunciator	2014	2,716		20	136	136	487	3
4	Lintel Replacement / Tuckpointing	2014	34,944		20	1,747	1,747	5,387	4
5	Walk In Cooler	2015	2,516		20	252	252	650	5
6	Tuckpointing	2016	37,900		20	3,790	3,790	5,685	6
7	Fire Detection System	2016	6,914		20	691	691	922	7
8	Tear Off And Replacement Of North And West Canopies	2017	5,650		20	330	330	330	8
9	Accutech - Resident Guard Wander Management System Door Ki	2017	3,317		20	332	332	332	9
10	Rising Development - Roof Repairs	2017	51,400		20	245	245	245	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)		\$ 2,452,163	\$ 200,530		\$ 68,072	\$ (132,458)	\$ 1,884,182	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:

01/01/17

Ending:

12/31/17

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		\$ 2,452,163	\$ 200,530		\$ 68,072	\$ (132,458)	\$ 1,884,182	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		\$ 2,452,163	\$ 200,530		\$ 68,072	\$ (132,458)	\$ 1,884,182	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		\$ 2,452,163	\$ 200,530		\$ 68,072	\$ (132,458)	\$ 1,884,182	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		\$ 2,452,163	\$ 200,530		\$ 68,072	\$ (132,458)	\$ 1,884,182	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:

01/01/17

Ending:

12/31/17

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		\$ 2,452,163	\$ 200,530		\$ 68,072	\$ (132,458)	\$ 1,884,182	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		\$ 2,452,163	\$ 200,530		\$ 68,072	\$ (132,458)	\$ 1,884,182	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	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.

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		\$	\$		\$	\$	\$	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.

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	123,248	3,160	20	3,160		47,274	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare	2003	5,709		20	285	285	4,156	9
10	Allocated from Staycare	2016	6,705		20	335	335	559	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)		\$ 135,662	\$ 3,160		\$ 3,780	\$ 620	\$ 51,989	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		\$ 135,662	\$ 3,160		\$ 3,780	\$ 620	\$ 51,989	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)	\$ 135,662	\$ 3,160		\$ 3,780	\$ 620	\$ 51,989	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:

01/01/17

Ending:

12/31/17

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	\$ 652,243	\$	\$ 14,079	\$ 14,079	10	\$ 626,329	71
72	Current Year Purchases	11,526		1,998	1,998	10	1,998	72
73	Fully Depreciated Assets	494,634				10	494,634	73
74								74
75	TOTALS	\$ 1,158,403	\$	\$ 16,077	\$ 16,077		\$ 1,122,961	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	\$ 8,728	\$ 418	\$ 1,063	\$ 645	5	\$ 6,734	76
77										77
78										78
79										79
80	TOTALS			\$ 8,728	\$ 418	\$ 1,063	\$ 645		\$ 6,734	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)	\$ 3,756,900	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 200,948	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 85,212	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (115,736)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,013,877	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	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2018 \$ _____

13. _____ /2019 \$ _____

14. _____ /2020 \$ _____

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		\$	\$ 7,288	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 7,288	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	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.

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	\$		\$	131,059	\$		\$	131,059	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				61,904				61,904	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				149,396				149,396	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					92,498			92,498	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): _____						400	117			517	13
14	TOTAL			\$		\$	342,759	\$	92,615	\$	435,374	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.

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of **12/31/17**

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,147,860	\$ 1,305,011	1
2	Cash-Patient Deposits	113,938	113,938	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,294,626	1,294,626	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	403,590	403,590	6
7	Other Prepaid Expenses	2,985	2,985	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	600	600	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,963,599	\$ 3,120,750	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	1,018,114	1,018,114	15
16	Equipment, at Historical Cost	384,118	864,118	16
17	Accumulated Depreciation (book methods)	(997,469)	(5,431,202)	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	109,469	44,100	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 514,232	\$ 1,215,753	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,477,831	\$ 4,336,503	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 446,695	\$ 446,695	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	113,810	113,810	28
29	Short-Term Notes Payable	9,675	9,675	29
30	Accrued Salaries Payable	254,892	254,892	30
31	Accrued Taxes Payable (excluding real estate taxes)	(271)	(271)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	108,155	108,155	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	146,647	146,647	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,079,603	\$ 1,079,603	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,042,387	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)	\$	\$ 4,042,387	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,079,603	\$ 5,121,990	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,398,228	\$ (785,487)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,477,831	\$ 4,336,503	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,947,901	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(5)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,947,896	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	450,332	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)	\$ 450,332	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)	\$ 2,398,228	24 *

* 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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 7,565,126	1
2	Discounts and Allowances for all Levels	881,556	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,446,682	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	740,640	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 740,640	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	91,725	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,371	19
20	Radiology and X-Ray		20
21	Other Medical Services	13,331	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 108,427	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	6,598	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 6,598	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	20,801	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 20,801	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,323,148	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,265,618	31
32	Health Care	2,463,436	32
33	General Administration	1,977,859	33
B. Capital Expense			
34	Ownership	2,332,819	34
C. Ancillary Expense			
35	Special Cost Centers	436,494	35
36	Provider Participation Fee	396,590	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,872,816	40
41	Income before Income Taxes (line 30 minus line 40)**	450,332	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 450,332	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,471,014	44
45	Private Pay - Net Inpatient Revenue	30,670	45
46	Medicare - Net Inpatient Revenue	881,556	46
47	Other-(specify) <u>Veterans</u>	63,442	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,446,682	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:

01/01/17

Ending:

12/31/17

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	3,772	4,156	\$ 169,941	\$ 40.89	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,711	10,973	360,428	32.85	3
4	Licensed Practical Nurses	21,605	24,349	674,516	27.70	4
5	CNAs & Orderlies	47,303	54,795	638,720	11.66	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,946	2,284	29,667	12.99	8
9	Activity Director	1,616	1,738	22,698	13.06	9
10	Activity Assistants	5,540	5,747	62,878	10.94	10
11	Social Service Workers	6,603	6,859	145,475	21.21	11
12	Dietician					12
13	Food Service Supervisor	1,985	2,077	34,822	16.77	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,122	19,983	243,057	12.16	15
16	Dishwashers					16
17	Maintenance Workers	4,718	5,192	96,526	18.59	17
18	Housekeepers	15,612	17,304	201,160	11.63	18
19	Laundry	4,852	5,253	66,433	12.65	19
20	Administrator	2,190	2,305	111,943	48.57	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,061	9,714	117,896	12.14	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	808	942	15,782	16.75	31
32	Other Health Care(specify)					32
33	Other(specify)	5,669	6,091	215,447	35.37	33
34	TOTAL (lines 1 - 33)	161,113	179,762	\$ 3,207,389 *	\$ 17.84	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	\$ 9,936	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,139	10-03	39
40	Physical Therapy Consultant	46	2,228	10a-03	40
41	Occupational Therapy Consultant	11	551	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	10	473	10a-03	43
44	Activity Consultant	12	630	11-03	44
45	Social Service Consultant	65	3,585	12-03	45
46	Other(specify)				46
47	Religious Services	Monthly	3,100	12-03	47
48	MDS Consulting	Monthly	18,000	10-03	48
49	TOTAL (lines 35 - 48)	144	\$ 76,642		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: 01/01/17

Ending: 12/31/17

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Aharon Diena	Administrator	0	\$ 111,943	Workers' Compensation Insurance	\$ 59,726	IDPH License Fee	\$	
				Unemployment Compensation Insurance	13,891	Advertising: Employee Recruitment		
				FICA Taxes	235,682	Health Care Worker Background Check	3,330	
				Employee Health Insurance	126,308	(Indicate # of checks performed <u>333</u>)		
				Employee Meals	39,807	Patient Background Checks		
				Illinois Municipal Retirement Fund (IMRF)*		Dues & Subscriptions	15,040	
				Christmas Expense	5,502	Licenses/Permits and Fees	5,179	
				Other Employee Benefits	1,591			
				Union Pension Expense	22,001			
				401K	478			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 111,943	TOTAL (agree to Schedule V, line 22, col.8)		\$ 504,986		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
Staycare Management - Management Fees			\$ 517,175				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 517,175				Seminar Expense	750
C. Professional Services				TOTAL			Allocated from Staycare	
Vendor/Payee	Type		Amount	\$			209	
Staycare Management	Admissions Consulting		\$ 28,682				Entertainment Expense	
Marcum LLP	Accounting		23,372				(
See Attached	Legal Fees		118,362				(
Personnel Planners	Unemployment Consultant		950				(
KBC Computer Services	Computer Services		5,298				(
Ehealth Solutions	Data Processing		21,803				(
2401 Incorporated	Architectual Services		3,637				(
SigmaCare	Data Processing		10,901				(
							(
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 213,005				TOTAL (agree to Sch. V, line 24, col. 8)	
							\$ 959	

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/17

Ending:

12/31/17**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. ICLTC - \$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. \$ 22,723 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. \$ 396,590
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. \$ 39,807 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% Ln14
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