

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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

I. IDPH License ID Number: <u>0055459</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Atrium Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2020</u> to <u>12/31/2020</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1425 W Estes Ave</u> <u>Chicago</u> <u>60626</u>																									
Number City Zip Code																									
County: <u>Cook</u>																									
Telephone Number: <u>(773)973-4780</u> Fax # ()																									
HFS ID Number: _____		<table><tr><td rowspan="4">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Type or Print Name) _____</td></tr><tr><td>(Title) _____</td></tr><tr><td>(Signed) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Print Name and Title) <u>See Accountant's Report attached</u></td></tr><tr><td>(Firm Name & Address) <u>Mendel S Schneider CPA & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u></td></tr><tr><td>(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u></td></tr><tr><td>MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) _____	(Title) _____	(Signed) _____	Paid Preparer	(Print Name and Title) <u>See Accountant's Report attached</u>	(Firm Name & Address) <u>Mendel S Schneider CPA & Associates</u> <u>4051 Old Orchard Rd, Skokie, IL 60076</u>	(Telephone) <u>(847)933-1274</u> Fax # <u>(847)933-1283</u>	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630												
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	MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																								
Date of Initial License for Current Owners: <u>03/01/2019</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY, NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td></td></tr><tr><td></td><td>☐ Other _____</td><td></td></tr></table>		☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust			☐ Other _____	
☐ VOLUNTARY, NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL																							
☐ Charitable Corp.	☐ Individual	☐ State																							
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IRS Exemption Code _____	☐ Corporation	☐ Other _____																							
	☐ "Sub-S" Corp.	_____																							
	☒ Limited Liability Co.	_____																							
	☐ Trust																								
	☐ Other _____																								
In the event there are further questions about this report, please contact:																									
Name: <u>Mendel Schneider</u> Telephone Number: <u>(847)933-1274</u>																									
Email Address: _____																									

#	0055459	Report Period Beginning:	01/01/2020	Ending:	12/31/2020
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D. How many bed reserve days during this year were paid by the Department?

0 (Do not include bed reserve days in Section B.)

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

None

Yes

YES ☐ NO ☒

YES ☐ **NO** ☒

Date started 03/01/2019

YES ☒ Date 03/01/2019 NO ☐

YES ☒ NO ☐ If YES, enter number

of beds certified **116** **and days of care provided** **2,703**

Medicare Intermediary Wisconsin Physician Services**MODIFIED**

ACCRUAL	X	CASH*		CASH*	
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31 **Fiscal Year:** 12/31

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

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) **91.07%**

Facility Name & ID Number Atrium Health Care Center # 0055459 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	381,543	50,772	10,976	443,291		443,291	11,479	454,770			1
2	Food Purchase		385,399		385,399		385,399	(336)	385,063			2
3	Housekeeping	321,047	39,709	11,988	372,744		372,744		372,744			3
4	Laundry	115,500	7,000	13,960	136,460		136,460		136,460			4
5	Heat and Other Utilities			141,592	141,592		141,592	2,365	143,957			5
6	Maintenance	129,550	37,933	58,511	225,994		225,994	2,805	228,799			6
7	Other (specify):*											7
8	TOTAL General Services	947,640	520,813	237,027	1,705,480		1,705,480	16,313	1,721,793			8
	B. Health Care and Programs											
9	Medical Director			27,000	27,000		27,000		27,000			9
10	Nursing and Medical Records	2,585,083	221,978	16,813	2,823,874		2,823,874		2,823,874			10
10a	Therapy											10a
11	Activities	143,588	1,894	1,071	146,553		146,553		146,553			11
12	Social Services	132,554		709	133,263		133,263		133,263			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,861,225	223,872	45,593	3,130,690		3,130,690		3,130,690			16
	C. General Administration											
17	Administrative	103,504		626,500	730,004		730,004	(521,081)	208,923			17
18	Directors Fees											18
19	Professional Services			157,422	157,422		157,422	(136,955)	20,467			19
20	Dues, Fees, Subscriptions & Promotions			39,486	39,486		39,486	(1,164)	38,322			20
21	Clerical & General Office Expenses	98,169	37,831	272,053	408,053		408,053	134,810	542,863			21
22	Employee Benefits & Payroll Taxes			559,345	559,345		559,345		559,345			22
23	Inservice Training & Education											23
24	Travel and Seminar			285	285		285	189	474			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			429,928	429,928		429,928	15,587	445,515			26
27	Other (specify):* Allocated benifets							103,718	103,718			27
28	TOTAL General Administration	201,673	37,831	2,085,019	2,324,523		2,324,523	(404,896)	1,919,627			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,010,538	782,516	2,367,639	7,160,693		7,160,693	(388,583)	6,772,110			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.

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			221,108	221,108		221,108	(130,534)	90,574			30
31	Amortization of Pre-Op. & Org.							400,359	400,359			31
32	Interest							492,522	492,522			32
33	Real Estate Taxes							253,157	253,157			33
34	Rent-Facility & Grounds			2,100,000	2,100,000		2,100,000	(2,100,000)				34
35	Rent-Equipment & Vehicles							13,584	13,584			35
36	Other (specify):* MIP							123,860	123,860			36
37	TOTAL Ownership			2,321,108	2,321,108		2,321,108	(947,052)	1,374,056			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		325,818	61,822	387,640		387,640		387,640			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			395,134	395,134		395,134		395,134			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		325,818	456,956	782,774		782,774		782,774			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,010,538	1,108,334	5,145,703	10,264,575		10,264,575	(1,335,635)	8,928,940			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.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(292,738)	30		9
10	Interest and Other Investment Income	(19,542)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(336)	2		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	(86,226)	21		24
25	Fund Raising, Advertising and Promotional	(1,272)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(30,696)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (430,810)		\$	30

BHF USE ONLY								
48		49		50		51		52

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(904,825)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (904,825)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,335,635)		37

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

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

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
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				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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Atrium Health Care Center# 0055459

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	11,479	0	0	0	0	0	0	0	0	11,479	1
2	Food Purchase	(336)	0	0	0	0	0	0	0	0	0	0	(336)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,365	0	0	0	0	0	0	0	0	2,365	5
6	Maintenance	0	0	2,805	0	0	0	0	0	0	0	0	2,805	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(336)	0	16,649	0	0	0	0	0	0	0	0	16,313	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	(202,331)	0	(318,750)	0	0	0	0	0	0	(521,081)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	250	(139,864)	1,467	1,192	0	0	0	0	0	0	(136,955)	19
20	Fees, Subscriptions & Promotions	(1,272)	0	0	0	108	0	0	0	0	0	0	(1,164)	20
21	Clerical & General Office Expenses	(116,922)	0	249,674	0	2,058	0	0	0	0	0	0	134,810	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	189	0	0	0	0	0	0	0	0	189	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	10,271	3,848	1,468	0	0	0	0	0	0	0	15,587	26
27	Other (specify):*	0	0	103,718	0	0	0	0	0	0	0	0	103,718	27
28	TOTAL General Administration	(118,194)	10,521	15,234	2,935	(315,392)	0	0	0	0	0	0	(404,896)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(118,530)	10,521	31,883	2,935	(315,392)	0	0	0	0	0	0	(388,583)	29

STATE OF ILLINOIS

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(292,738)	162,204	0	0	0	0	0	0	0	0	0	(130,534)	30
31	Amortization of Pre-Op. & Org.	0	400,359	0	0	0	0	0	0	0	0	0	400,359	31
32	Interest	(19,542)	511,931	0	133	0	0	0	0	0	0	0	492,522	32
33	Real Estate Taxes	0	245,845	0	7,312	0	0	0	0	0	0	0	253,157	33
34	Rent-Facility & Grounds	0	(2,100,000)	29,195	(29,195)	0	0	0	0	0	0	0	(2,100,000)	34
35	Rent-Equipment & Vehicles	0	0	13,584	0	0	0	0	0	0	0	0	13,584	35
36	Other (specify):*	0	123,860	0	0	0	0	0	0	0	0	0	123,860	36
37	TOTAL Ownership	(312,280)	(655,801)	42,779	(21,750)	0	0	0	0	0	0	0	(947,052)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(430,810)	(645,280)	74,662	(18,815)	(315,392)	0	0	0	0	0	0	(1,335,635)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6 Supplemental		See Page 6 Supplemental		See Page 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	\$ 2,100,000	Atrium Health Care Center LLC	100.00%	\$	(2,100,000)	1
2	V	32	Mortgage Interest	594	Atrium Health Care Center LLC		512,525	511,931	2
3	V	33	Real Estate Tax		Atrium Health Care Center LLC		245,845	245,845	3
4	V	30	Depreciation		Atrium Health Care Center LLC		162,204	162,204	4
5	V	31	Amortization		Atrium Health Care Center LLC		400,359	400,359	5
6	V	26	Insurance		Atrium Health Care Center LLC		10,271	10,271	6
7	V	19	Professional Services		Atrium Health Care Center LLC		250	250	7
8	V	36	MIP		Atrium Health Care Center LLC		123,860	123,860	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 2,100,594			\$ 1,455,314	\$ * (645,280)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	<u>5</u> Utilities	\$	<u>Staycare Management</u>		\$ 2,365	\$ 2,365	15
16	V	<u>6</u> Repairs & Maintenance		<u>Staycare Management</u>		2,805	2,805	16
17	V	<u>17</u> Admin Salary		<u>Staycare Management</u>		105,419	105,419	17
18	V	<u>19</u> Professional Fees		<u>Staycare Management</u>		718	718	18
19	V	<u>21</u> Clerical Salaries		<u>Staycare Management</u>		292,157	292,157	19
20	V	<u>21</u> Office Supplies		<u>Staycare Management</u>		18,417	18,417	20
21	V	<u>26</u> Insurance		<u>Staycare Management</u>		3,848	3,848	21
22	V	<u>27</u> Health Insurance		<u>Staycare Management</u>		62,996	62,996	22
23	V	<u>1</u> Dietary Salary-S Webster		<u>Staycare Management</u>		2,892	2,892	23
24	V	<u>1</u> Dietary Salary-D Wengrow		<u>Staycare Management</u>		8,587	8,587	24
25	V	<u>24</u> Seminars		<u>Staycare Management</u>		189	189	25
26	V	<u>34</u> Rent		<u>Staycare Management</u>		29,195	29,195	26
27	V	<u>27</u> Payroll taxes		<u>Staycare Management</u>		25,963	25,963	27
28	V	<u>27</u> Employee Benifets		<u>Staycare Management</u>		14,759	14,759	28
29	V	<u>35</u> Equipment Rental -Auto		<u>Staycare Management</u>		13,584	13,584	29
30	V							30
31	V	<u>17</u> Management Fees	307,750	<u>Staycare Management</u>			(307,750)	31
32	V	<u>19</u> Administrative Consultant	140,582	<u>Staycare Management</u>			(140,582)	32
33	V	<u>21</u> Admissions Director	27,500	<u>Staycare Management</u>			(27,500)	33
34	V	<u>21</u> Reimbursement Consultant	33,400	<u>Staycare Management</u>			(33,400)	34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 509,232			\$ 583,894	\$ * 74,662	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 Professional Fees	\$	Double You Realty		\$ 1,467	\$ 1,467	15
16	V	26 Insurance		Double You Realty		1,468	1,468	16
17	V	30 Depreciation		Double You Realty		0		17
18	V	32 Interest Expense		Double You Realty		133	133	18
19	V	33 Real Estate Taxes		Double You Realty		7,312	7,312	19
20	V					252	252	20
21	V	34 Rent	29,195	Double You Realty			(29,195)	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		\$ 29,195			\$ 10,632	\$ * (18,563)	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 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 Professional fees	\$	AE Financial Services		\$ 1,192	\$ 1,192	15
16	V	20 License		AE Financial Services		108	108	16
17	V	21 Office		AE Financial Services		2,058	2,058	17
18	V							18
19	V	17 Management Fees	318,750	AE Financial Services			(318,750)	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		\$ 318,750			\$ 3,358	\$ * (315,392)	39

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

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	<u>Ephraim Braunstein</u>	<u>31.25</u>	<u>Arbour Health Care Center, LTD</u>	<u>Chicago</u>	<u>Atrium Health Care Ce</u>	<u>Chicago</u>	<u>Bldg rental</u>	1
2	<u>Aharon Dena</u>	<u>31.25</u>	<u>All American Nursing Home</u>	<u>Chicago</u>	<u>StayCare Management</u>	<u>Lincolnwood</u>	<u>Management</u>	2
3	<u>Jeffrey Webster</u>	<u>3.125</u>	<u>Abbington Rehan & Nursing, LTD</u>	<u>Roselle</u>	<u>AE Financial</u>	<u>Lincolnwood</u>	<u>Management</u>	3
4	<u>Sara Webster</u>	<u>3.125</u>	<u>Hickory Nursing Pavilion,Inc</u>	<u>Hickory Hills</u>	<u>Double You realty</u>	<u>Lincolnwood</u>	<u>Bldg rental</u>	4
5	<u>Howard Wengrow</u>	<u>22.5</u>						5
6	<u>Jay Wengrow</u>	<u>4.375</u>						6
7	<u>Robin Wengrow</u>	<u>4.375</u>						7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Atrium Health Care Center # 0055459 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Howard Wengrow	Owner	Administrative	22.50	126,013	8	20.00	Alloc Salary	\$ 50,532	17-7	1
2	Jeffrey Webster	Owner	Administrative	3.13	136,874	8	20.00	Alloc Salary	54,887	17-7	2
3	Debbie wengrow	Relative	Dietary	0.00	21,413	8	20.00	Alloc Salary	8,587	1-7	3
4	Sara Webster	Owner	Dietary	3.13	7,212	8	20.00	Alloc Salary	2,892	1-7	4
5	Aharon Diena	Owner	Administrative	31.25		30	75.00	aloc Salary/mgmt	157,696	21-7 17-3	5
6	Ephraim Braunstein	Owner	Administrative	31.25		30	75.00	aloc Salary/mgmt	157,696	21-7 17-4	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 432,290		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# 0055459 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

Facility Name & ID Number Atrium Health Care Center# 0055459 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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

Street Address

3737 W Arthur

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847)679-2121

Fax Number

(847)679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Number of Beds	559	5	\$ 8,261	\$	160	\$ 2,365	1
2	6	Repairs & Maintenance	Number of Beds	559	5	9,800		160	2,805	2
3	17	Admin Salary-H Wengrow	Number of Beds	559	5	176,545	176,545	160	50,532	3
4	17	Admin Salary-J Webster	Number of Beds	559	5	191,761	191,761	160	54,887	4
5	19	Professional Fees	Number of Beds	559	5	2,509		160	718	5
6	21	Clerical Salaries	Number of Beds	559	5	1,020,725	1,020,725	160	292,157	6
7	21	Office Supplies	Number of Beds	559	5	64,344		160	18,417	7
8	26	Insurance	Number of Beds	559	5	13,444		160	3,848	8
9	27	Health Insurance	Number of Beds	559	5	220,093		160	62,996	9
10	1	Dietary Salary-S Webster	Number of Beds	559	5	10,104	10,104	160	2,892	10
11	1	Dietary Salary-D Wengrow	Number of Beds	559	5	30,000	30,000	160	8,587	11
12	24	Seminars	Number of Beds	559	5	660		160	189	12
13	34	Rent	Number of Beds	559	5	102,000		160	29,195	13
14	27	Payroll taxes	Number of Beds	559	5	90,708		160	25,963	14
15	27	Employee Benifets	Number of Beds	559	5	51,563		160	14,759	15
16	35	Equipment Rental -Auto	Number of Beds	559	5	47,460		160	13,584	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 2,039,977	\$ 1,429,135		\$ 583,894	25

Facility Name & ID Number Atrium Health Care Center# 0055459

Report Period Beginning:

01/01/2020Ending: 2/31/2020

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

Street Address

3737 W Arthur Ave

City / State / Zip Code

Lincolnwood, IL 60712

Phone Number

(847)679-2121

Fax Number

(847)679-2122

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees		559	5	\$ 5,127	\$	160	\$ 1,467	1
2	26	Insurance		559	5	5,130		160	1,468	2
3	30	Depreciation		559	5					3
4	32	Interest Expense		559	5	465		160	133	4
5	33	Real Estate Taxes		559	5	25,547		160	7,312	5
6	21	Office Supplies		559	5	881		160	252	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					\$ 37,150	\$		\$ 10,632	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6	7	8	9	10		
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Greystone		X	Mortgage		03/01/2019	\$	13,361,595			\$ 512,525	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	13,361,595			\$ 512,525	9	
	B. Non-Facility Related*												
10	Interest Income										(20,136)	10	
11	Allocated from Double You Realty										133	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$				\$ (20,003)	14	
15	TOTALS (line 9+line14)							\$	13,361,595			\$ 492,522	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 123,860 Line # 36

* 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

[illegible]

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 Atrium Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0055459

CONTACT PERSON REGARDING THIS REPORT Mendel Schenider

TELEPHONE (847)933-1274 FAX #: (847)933-1283

Enter the tax index number and real estate tax assessed for 2019 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 2019.

B. Real Estate Tax Cost Allocations

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.)

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

Page 10A

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: 604,359

2. Number of Years Over Which it is Being Amortized: 15

3. Current Period Amortization: 400,359

4. Dates Incurred: 03/01/2019,01/29/2020

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>26,895</u>	<u>1975</u>	<u>\$ 124,712</u>	1
2	<u>Allocated from Double You realty</u>			<u>12,578</u>	2
3	TOTALS	26,895		\$ 137,290	3

HFS 3745 (N-4-99)

IL478-2471

XI. OWNERSHIP COSTS (continued)

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

	1	FOR BHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	160			1970	\$ 574,854	\$ 162,205		\$	(162,205)	\$ 919,825	4
5				1972	344,971						5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1972	50,343		20				9
10	Various			1974	12,941		20				10
11	Various			1977	46,500		20				11
12	Various			1978	23,362		20				12
13	Various			1979	11,676		20			1,354	13
14	Various			1980	12,652		20			580	14
15	Various			1981	4,095		20			393	15
16	Various			1982	1,310		20			1,310	16
17	Various			1989	42,200		20			35,799	17
18	Various			1992	16,375		20			15,185	18
19	Various			1993	26,090		20			24,566	19
20	Various			1995	32,183		20			31,833	20
21	Various			1996	71,604		20			70,977	21
22	Various			1997	52,684		20			52,682	22
23	Various			1998	131,108		20			131,108	23
24	Various			1999	9,413		20			9,413	24
25	Various			2000	67,328		20	1,670	1,670	47,255	25
26	Various			2001	13,010		20	651	651	12,803	26
27	Various			2002	5,102		20			5,102	27
28	Various			2003	55,595		20	796	796	54,652	28
29	Various			2004	7,347		20	223	223	6,602	29
30	Various			2005	15,308		20	141	141	14,640	30
31	Various			2006	47,619		20	281	281	46,025	31
32	Various			2007	6,765		20	338	338	4,707	32
33	Various			2008	48,015		20	1,494	1,494	48,247	33
34	Various			2009	87,312		20	3,168	3,168	90,480	34
35	Various			2010	52,946		20	5,009	5,009	52,214	35
36											36

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number **Atrium Health Care Center**

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	2011	\$ 25,166	\$	20	\$ 1,961	\$ 1,961	\$ 24,402	37
38	Various	2012	148,718		20	6,826	6,826	135,780	38
39	Various	2013	123,401		20	12,199	12,199	92,569	39
40	Various	2014	40,810		20	2,041	2,041	12,561	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	Financial statement Depreciation			221,108			(221,108)		66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,208,803	\$ 383,313		\$ 36,798	\$ (346,515)	\$ 1,943,064	70

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

Facility Name & ID Number Atrium Health Care Center

0055459

Report Period Beginning:

01/01/2020

Ending:

12/31/2020

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		\$ 2,208,803	\$ 383,313		\$ 36,798	\$ (346,515)	\$ 1,943,064	1
2	Walk In cooler	2015	2,516		20	252	252	1,406	2
3	Tuckpointing	2016	37,900		20	3,790	3,790	17,055	3
4	Fire detection System	2016	6,914		20	691	691	2,995	4
5	Tear Off And replacement of North and West Canopies	2017	5,650		20	283	283	1,013	5
6	Accutech-Resident Guard Wander Mgmt System Door Kit	2017	3,317		20	166	166	581	6
7	Rising Development-Roof repairs	2017	51,400		20	2,570	2,570	8,138	7
8	Generator Project	2018	139,260		20	6,383	6,383	19,149	8
9	Heavy Duty Safety Bollard	2018	2,580		20	129	129	355	9
10	State Water Heater	2018	20,698		20	1,035	1,035	2,760	10
11	Concrete Repairs	2018	14,850		20	743	743	2,229	11
12	Left Boiler Parts& Steam Table Parts	2019	3,057		20	153	153	306	12
13	Gas regulator For Generator	2019	12,600		20	630	630	1,260	13
14	2 Ton Mini Split A/C	2019	8,500		20	425	425	850	14
15	New Water Heater	2019	16,740		20	837	837	1,674	15
16	Installed electricity for elevator Modernization	2019	25,130		20	1,257	1,257	2,514	16
17	Elavator Modernization project-Suburban Elevator	2019	122,804		20	6,140	6,140	12,280	17
18	New Door handles	2019	3,924		20	196	196	392	18
19	Grab Bars	2019	450		20	23	23	46	19
20	Scald & Abrasion Tubing	2019	1,936		20	97	97	194	20
21	Smoke Detectors	2019	826		20	41	41	82	21
22	Modify Existing Railing on Stairs and handicap ramp to make ADA	2019	7,999		20	400	400	800	22
23	Install New gas line to new generatorGenerator	2019	4,705		20	235	235	9,410	23
24	Install 7 RPZ	2019	7,000		20	350	350	700	24
25	Removal and Installation of 83 new windows in residnet rooms	2020	126,843		20	6,342	6,342	6,342	25
26	Purchase of Cooling Tower Replacement	2020	54,893		20	2,745	2,745	2,745	26
27	Install of 2 building heating and cooling pumps	2020	3,154		20	158	158	158	27
28	Install new facility sign	2020	3,506		20	175	175	175	28
29	Asphalt resurface of Facility Parking Lot	2020	22,975		20	1,149	1,149	1,149	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,920,930	\$ 383,313		\$ 74,193	\$ (309,120)	\$ 2,039,822	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	Totals from Page 12B, Carried Forward		\$ 2,920,930	\$ 383,313		\$ 74,193	\$ (309,120)	\$ 2,039,822	1
2	Related Party								2
3	Buildings:								3
4	Allocated from Staycare Management	2003	120,233			3,083	3,083	55,366	4
5									5
6	Leasehold Improvements:								6
7	Allocated from Staycare Management		6,541			327	327	1,526	7
8	Allocated from Staycare Management		5,569			278	278	4,889	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)		\$ 3,053,273	\$ 383,313		\$ 77,881	\$ (305,432)	\$ 2,101,603	34

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

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$123,817	\$	\$12,381	\$12,381	10	\$114,240	71
72	Current Year Purchases	3,121		312	312	10	312	72
73	Fully Depreciated Assets	1,042,680					1,042,680	73
74								74
75	TOTALS	\$1,169,618	\$	\$12,693	\$12,693		\$1,157,232	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 mgmt	2012	\$8,514	\$	\$	\$		\$8,514
77									
78									
79									
80	TOTALS			\$8,514	\$	\$	\$		\$8,514

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	4,368,695
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	383,313
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	90,574
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(292,739)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	3,267,349

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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?

YES

NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

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

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

9. Option to Buy:

YES

NO

Terms: *

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

15. Is Movable equipment rental included in building rental?

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 Mgmt		\$	\$13,584	17
18					18
19					19
20					20
21	TOTAL		\$	\$13,584	21

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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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.

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

(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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$ 145,923		\$	\$		\$ 145,923	1
2	Licensed Speech and Language Development Therapist	39-3	hrs	15,950					15,950	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs	163,945					163,945	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				61,822		61,822	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			\$ 325,818		\$	\$ 61,822		\$ 387,640	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.

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	\$ 1,495,523	\$ 285,847	1
2	Cash-Patient Deposits	222,179	222,179	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,617,776	1,617,776	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,908	109,359	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrows</u>		539,396	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,420,386	\$ 2,774,557	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	1,470,179	1,595,714	15
16	Equipment, at Historical Cost	392,277	872,277	16
17	Accumulated Depreciation (book methods)	(1,249,235)	(6,295,115)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		604,359	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(423,909)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 613,221	\$ 1,073,949	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,033,607	\$ 3,848,506	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 314,280	\$ 316,342	26
27	Officer's Accounts Payable	222,179	222,179	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	690,792	690,792	29
30	Accrued Salaries Payable	245,266	245,266	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,713	2,713	31
32	Accrued Real Estate Taxes(Sch.IX-B)		246,533	32
33	Accrued Interest Payable		38,415	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,475,230	\$ 1,762,240	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		13,361,595	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)	\$	\$ 13,361,595	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,475,230	\$ 15,123,835	46
47	TOTAL EQUITY (page 18, line 24)	\$ 2,558,377	\$ (11,275,329)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,033,607	\$ 3,848,506	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,446,182	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,446,182	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,366,519	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	(1,200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Related Party Adjustments	(2,054,324)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,887,805)	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)	\$ 2,558,377	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Atrium Health Care Center

0055459

Report Period Beginning: 01/01/2020

Ending:

12/31/2020

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	\$ 10,317,398	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 10,317,398	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,542	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,542	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28		1,294,154	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,294,154	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 11,631,094	30

2			
	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,705,480	31
32	Health Care	3,130,690	32
33	General Administration	2,324,523	33
	B. Capital Expense		
34	Ownership	2,321,108	34
	C. Ancillary Expense		
35	Special Cost Centers	387,640	35
36	Provider Participation Fee	395,134	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,264,575	40
41	Income before Income Taxes (line 30 minus line 40)**	1,366,519	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,366,519	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 8,305,691	44
45	Private Pay - Net Inpatient Revenue	111,915	45
46	Medicare - Net Inpatient Revenue	1,708,998	46
47	Other-(specify)	61,565	47
48	Other-(specify)	129,229	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 10,317,398	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No, 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.

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	4,442	4,914	\$ 220,642	\$ 44.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,516	11,350	448,805	39.54	3
4	Licensed Practical Nurses	25,460	27,691	867,314	31.32	4
5	CNAs & Orderlies	53,112	57,341	1,003,703	17.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,187	2,459	44,619	18.15	8
9	Activity Director	2,430	2,718	44,393	16.33	9
10	Activity Assistants	6,226	6,560	99,195	15.12	10
11	Social Service Workers	7,121	7,542	132,554	17.58	11
12	Dietician					12
13	Food Service Supervisor	1,962	2,119	38,725	18.28	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,638	20,924	342,818	16.38	15
16	Dishwashers					16
17	Maintenance Workers	4,158	4,870	129,550	26.60	17
18	Housekeepers	18,171	20,317	321,047	15.80	18
19	Laundry	6,583	7,190	115,500	16.06	19
20	Administrator	2,032	2,160	103,504	47.92	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,905	7,336	98,169	13.38	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					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	169,943	185,491	\$ 4,010,538 *	\$ 21.62	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	\$ 10,976	1-3	35
36	Medical Director	Monthly	27,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	14,088	10-3	39
40	Physical Therapy Consultant	35	1,732	10-3	40
41	Occupational Therapy Consultant	16	782	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	212	10-3	43
44	Activity Consultant	21	1,071	11-3	44
45	Social Service Consultant	14	709	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	90	\$ 56,570		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

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? <u>Yes</u> (2) Are there any dues to nursing home associations included on the cost report? <u>Yes</u> If YES, give association name and amount. <u>HCCI 28480</u> (3) Did the nursing home make political contributions or payments to a political action organization? <u>No</u> If YES, have these costs been properly adjusted out of the cost report? _____ (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? <u>No</u> If YES, what is the capacity? _____ (5) Have you properly capitalized all major repairs and equipment purchases? <u>Yes</u> What was the average life used for new equipment added during this period? <u>10</u> (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ <u>25,723</u> Line <u>10</u> (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? <u>Yes</u> If NO, attach a complete explanation. (8) Are you presently operating under a sale and leaseback arrangement? <u>No</u> If YES, give effective date of lease. _____ (9) Are you presently operating under a sublease agreement? _____ YES <u>X</u> NO (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES <u>X</u> NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. <u>Atrium Health Care Center 0033977 3/1/19</u> (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ <u>395,134</u> 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? <u>No</u> 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? <u>Yes</u> (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? <u>No</u> 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. \$ <u>0</u> Has any meal income been offset against related costs? <u>No</u> Indicate the amount. \$ _____ (16) Travel and Transportation a. Are there costs included for out-of-state travel? <u>No</u> If YES, attach a complete explanation. b. Do you have a separate contract with the Department to provide medical transportation for residents? <u>No</u> If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____ c. What percent of all travel expense relates to transportation of nurses and patients? <u>100</u> d. Have vehicle usage logs been maintained? <u>No</u> e. Are all vehicles stored at the nursing home during the night and all other times when not in use? <u>No</u> f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? <u>No</u> g. Does the facility transport residents to and from day training? <u>No</u> Indicate the amount of income earned from providing such transportation during this reporting period. \$ <u>0</u> (17) Has an audit been performed by an independent certified public accounting firm? <u>No</u> Firm Name: _____ (18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? <u>Yes</u> (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. <u>Yes</u> Attach invoices and a summary of services for all architect and appraisal fees.
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