

		FOR BHF USE					

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2025
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2025)

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: 0055459

Facility Name: Atrium Health Care Center

Address: 1425 W Estes Ave Chicago 60626
Number City Zip Code

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 03/01/2019

Type of Ownership:

VOLUNTARY, NON-PROFIT
Charitable Corp.
Trust
IRS Exemption Code

X PROPRIETARY
Individual
Partnership
Corporation
"Sub-S" Corp.
X Limited Liability Co.
Trust
Other

GOVERNMENTAL
State
County
Other

In the event there are further questions about this report, please contact:
Name: Judd Schneider Telephone Number: (847)933-1274
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2025 to 12/31/2025 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer

(Signed) (Date)
(Print Name and Title) See Accountant's Report Attached
(Firm Name & Address) Mendel S Schneider & Associates CPA PC
4051 Old Orchard Rd Skokie, Illinois 60076
(Telephone) (847)933-1274 Fax # (847)933-1283

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number Atrium Health Care Center # 0055459 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	160	58,400	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	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	6,219	35,409	9,518		1,065	707	972	53,890	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	6,219	35,409	9,518		1,065	707	972	53,890	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 92.28%

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 03/01/2019

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 03/01/2019 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter certified beds.
number of certified beds 116

Medicare Intermediary Wisconsin Physicians Service

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

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.

Facility Name & ID Number Atrium Health Care Center # 0055459 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	519,077	65,854	12,546	597,477		597,477		597,477			1
2	Food Purchase		587,026		587,026		587,026	(420)	586,606			2
3	Housekeeping	443,006	55,336	16,865	515,207		515,207		515,207			3
4	Laundry	131,869	18,723		150,592		150,592		150,592			4
5	Heat and Other Utilities			177,608	177,608		177,608	4,560	182,168			5
6	Maintenance	171,512	46,147	94,687	312,346		312,346	237	312,583			6
7	Other (specify):*											7
8	TOTAL General Services	1,265,464	773,086	301,706	2,340,256		2,340,256	4,377	2,344,633			8
	B. Health Care and Programs											
9	Medical Director			26,000	26,000		26,000		26,000			9
10	Nursing and Medical Records	4,040,547	186,625	46,399	4,273,571		4,273,571		4,273,571			10
10a	Therapy											10a
11	Activities	156,949	4,054	1,407	162,410		162,410		162,410			11
12	Social Services	287,195		2,479	289,674		289,674		289,674			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	4,484,691	190,679	76,285	4,751,655		4,751,655		4,751,655			16
	C. General Administration											
17	Administrative	129,569		804,000	933,569		933,569	(735,975)	197,594			17
18	Directors Fees											18
19	Professional Services			317,762	317,762		317,762	(124,251)	193,511			19
20	Dues, Fees, Subscriptions & Promotions			73,816	73,816		73,816	(17,888)	55,928			20
21	Clerical & General Office Expenses	244,466	179,730	454,079	878,275		878,275	376,567	1,254,842			21
22	Employee Benefits & Payroll Taxes			769,368	769,368		769,368	53,949	823,317			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,398	2,398		2,398	608	3,006			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			226,497	226,497		226,497	78,347	304,844			26
27	Other (specify):*							86,263	86,263			27
28	TOTAL General Administration	374,035	179,730	2,647,920	3,201,685		3,201,685	(282,380)	2,919,305			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	6,124,190	1,143,495	3,025,911	10,293,596		10,293,596	(278,003)	10,015,593			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			64,607	64,607		64,607	3,159	67,766			30
31	Amortization of Pre-Op. & Org.							6,015	6,015			31
32	Interest			64,859	64,859		64,859	399,288	464,147			32
33	Real Estate Taxes							475,263	475,263			33
34	Rent-Facility & Grounds			1,620,000	1,620,000		1,620,000	(1,611,304)	8,696			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							78,347	78,347			36
37	TOTAL Ownership			1,749,466	1,749,466		1,749,466	(649,232)	1,100,234			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,770	229,604	344,374		344,374		344,374			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			853,326	853,326		853,326		853,326			42
43	Other (specify):* Bad Debt Expense			18,775	18,775		18,775	(18,775)				43
44	TOTAL Special Cost Centers		114,770	1,101,705	1,216,475		1,216,475	(18,775)	1,197,700			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	6,124,190	1,258,265	5,877,082	13,259,537		13,259,537	(946,010)	12,313,527			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	(14,883)	30		9
10	Interest and Other Investment Income	(14,438)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(420)	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	(15,908)	21		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	(18,775)	43		24
25	Fund Raising, Advertising and Promotional	(8,608)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (73,032)		\$	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)	(863,698)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (863,698)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (936,730)		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	Political Action Committee Payments	\$ (9,280)	20	1
2	Other Expenses Related to Lobbying Activities			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	(9,280)		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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

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	\$ 1,620,000	Atrium Health Care LLC		\$	(1,620,000)	1
2	V	32	Mortgage Interest	2,140	Atrium Health Care LLC		415,866	413,726	2
3	V	33	Real Estate Taxes		Atrium Health Care LLC		475,263	475,263	3
4	V	26	Insurance		Atrium Health Care LLC		78,347	78,347	4
5	V	19	Professional Fees		Atrium Health Care LLC		7,650	7,650	5
6	V	30	Depreciation		Atrium Health Care LLC		18,042	18,042	6
7	V	31	Amortization		Atrium Health Care LLC		6,015	6,015	7
8	V	36	MIP		Atrium Health Care LLC		78,347	78,347	8
9	V	21	Office		Atrium Health Care LLC				9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,622,140			\$ 1,079,530	\$ * (542,610)	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	17	Management Fees	\$ 804,000	AE FINANCIAL SERVICES		\$	(804,000)	15
16	V	21	Office Payroll				477,459	477,459	16
17	V	21	Office				64,286	64,286	17
18	V	27	Health Insurance				86,263	86,263	18
19	V	17	Administrative Salaries				68,025	68,025	19
20	V	6	Repairs & Maintenance				237	237	20
21	V	22	Payroll Taxes				53,949	53,949	21
22	V	34	Rent				8,696	8,696	22
23	V	19	Professional Fees	132,510			609	(131,901)	23
24	V	21	Office	149,270			0	(149,270)	24
25	V	5	Utilities				4,560	4,560	25
26	V	24	Seminar				608	608	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			\$ 1,085,780			\$ 764,692	\$ * (321,088)	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 related nursing homes and related organizations (parties) as defined in the instructions.

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1	Fargo Rehab & Nursing Center	Chicago,Il			AE Financial Service	Lincolwnood,Il	Mgmt	1
2	Irving Park Nursing & Rehab	Chicago,Il			Atrium Health Care L	Chicago,IL	Bld rental	2
3	North Aurora Living & Rehab Center	North Aurora,IL						3
4	Sandwich Living & Rehab Center	Sandwich,Il						4
5	South Elgin Living & Rehab Center	South Elgin,Il						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

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	Aharon Diena	Owner	Administrative	31.25	102,887	7	17.00	Allocated Wag	\$ 34,013	17-7	1
2	Ephraim Braunstein	Owner	Administrative	31.25	102,887	7	17.00	Allocated Wages	34,013	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 68,026		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

Ending: 2/31/2025

((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	21	Office Payroll	Number of Beds	644	6	\$ 1,921,773	\$	160	\$ 477,459	1
2	21	Office	Number of Beds	644	6	258,753		160	64,286	2
3	27	Health Insurance	Number of Beds	644	6	347,207		160	86,263	3
4	17	Administrative Salaries	Number of Beds	644	6	273,800		160	68,025	4
5	6	Repairs & Maintenance	Number of Beds	644	6	955		160	237	5
6	22	Payroll Taxes	Number of Beds	644	6	217,145		160	53,949	6
7	19	Professional Fees	Number of Beds	644	6	2,450		160	609	7
8	34	Rent	Number of Beds	644	6	35,000		160	8,696	8
9	5	Utilities	Number of Beds	644	6	18,356		160	4,560	9
10	24	Seminar	Number of Beds	644	6	2,449		160	608	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					\$ 3,077,888	\$		\$ 764,692	25

Ending: 2/31/2025

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

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			\$	11,910,911			\$	415,866	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Brickyard		X	Working Capital				1,077,101				64,859	6
7													7
8													8
9	TOTAL Facility Related						\$	12,988,012			\$	480,725	9
	B. Non-Facility Related*												
10	Interest income											(14,438)	10
11	Interest Income Propco											(2,140)	11
12													12
13													13
14	TOTAL Non-Facility Related						\$				\$	(16,578)	14
15	TOTALS (line 9+line14)						\$	12,988,012			\$	464,147	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 78,347 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

1. Real Estate Tax accrual used on 2024 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	401,845	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.)				\$	434,212	2
3. Under or (over) accrual (line 2 minus line 1).				\$	32,367	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	442,896	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	475,263	7
Assessed Value from Real Estate Tax Bill:	2024	2,161,251	8			
Real Estate Tax Bill for Calendar Year:	2020	267,992	9			
	2021	353,191	10			
	2022	348,494	11			
	2023	393,966	12			
	2024	434,212	13			
434212 X 1.02						

FOR BHF USE ONLY			
14	FROM R. E. TAX STATEMENT FOR 2024	\$	14
15	PLUS APPEAL COST FROM LINE 5	\$	15
16	LESS REFUND FROM LINE 6	\$	16
17	AMOUNT TO USE FOR RATE CALCULATION	\$	17

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
---------------	---------------------------	--------	------

CONTACT PERSON REGARDING THIS REPORT Judd Schneider

A. Summary of Real Estate Tax Cost

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to Nursing Home</u>

B. Real Estate Tax Cost Allocations

C. Tax Bills

Page 10A

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (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. List the bed capacity for the building if it differs from the licensed total. N/A
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

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

1. Total Amount Incurred: 180,450 2. Number of Years Over Which it is Being Amortized: 30
3. Current Period Amortization: 6,015 4. Dates Incurred: 02/01/2020

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	Facility	26,895		\$ 124,712	1
2					2
3	TOTALS	26,895		\$ 124,712	3

Facility Name & ID Number Atrium Health Care Center

0055459

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	\$		\$		\$ 919,825	4
5			1972		344,971						5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1972		50,343		20			50,343	9
10	Various		1974		12,941		20			12,941	10
11	Various		1977		46,500		20			46,500	11
12	Various		1978		23,362		20			23,362	12
13	Various		1979		11,676		20			11,676	13
14	Various		1980		12,652		20			12,652	14
15	Various		1981		4,095		20			4,095	15
16	Various		1982		1,310		20			1,310	16
17	Various		1989		42,200		20			42,200	17
18	Various		1992		16,375		20			16,375	18
19	Various		1993		26,090		20			26,090	19
20	Various		1995		32,183		20			32,183	20
21	Various		1996		71,604		20			71,604	21
22	Various		1997		52,684		20			52,684	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			67,328	25
26	Various		2001		13,010		20			13,010	26
27	Various		2002		5,102		20			5,102	27
28	Various		2003		55,595		20			55,595	28
29	Various		2004		7,347		20			7,347	29
30	Various		2005		15,308		20	104	104	15,308	30
31	Various		2006		47,619		20			47,619	31
32	Various		2007		6,765		20	338	338	6,397	32
33	Various		2008		48,015		20			48,015	33
34	Various		2009		87,312		20			87,312	34
35	Various		2010		52,946		20			52,946	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

0055459

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Various	2011	\$ 25,166	\$	20	\$	\$	\$ 25,166	37
38	Various	2012	148,718		20			148,718	38
39	Various	2013	123,401		20			123,401	39
40	Various	2014	40,810		20	2,041	2,041	22,766	40
41	Walk in Cooler	2015	2,516		20	252	252	2,666	41
42	Tuckpointing	2016	37,900		20	3,790	3,790	36,005	42
43	Fire Detection System	2016	6,914		20	691	691	6,450	43
44	Tear Off & Replacement of North & west Canopies	2017	5,650		20	283	283	2,428	44
45	Accutech-resider Guard wander Mgmt System Door Kit	2017	3,317		20	166	166	1,411	45
46	Rising Development-Roof Repairs	2017	51,400		20	2,570	2,570	20,988	46
47	Generator Project	2018	139,260		20	6,383	6,383	51,064	47
48	Heavy Duty Safety Bollard	2018	2,580		20	129	129	1,000	48
49	State Water Heater	2018	20,698		20	1,035	1,035	7,935	49
50	Concrete Repairs	2018	14,850		20	743	743	5,944	50
51	Left Boiler Parts & Steam Table Parts	2019	3,057		20	153	153	1,071	51
52	Gas Regulator for Generator	2019	12,600		20	630	630	4,410	52
53	2 Ton Split Mini A/c	2019	8,500		20	425	425	2,975	53
54	New Water Heater	2019	16,740		20	837	837	5,859	54
55	Installed Electricity for Elevator Modernization	2019	25,130		20	1,257	1,257	8,799	55
56	Elevator Modernization Project-Suburban Elevator	2019	122,804		20	6,140	6,140	42,980	56
57	New Door Handles	2019	3,924		20	196	196	1,372	57
58	Grab Bars	2019	450		20	23	23	161	58
59	Scald & Abrasion Tubing	2019	1,936		20	97	97	682	59
60	Smoke Detectors	2019	826		20	41	41	287	60
61	Modify Existing Railing on Stairs & Handicap Ramp	2019	7,999		20	400	400	2,800	61
62	Install New Gas line For New Generator	2019	4,705		20	235	235	1,645	62
63	Install 7 RPZ	2019	7,000		20	350	350	2,450	63
64	Removal & Installation of 83 New Windows in Resident Rooms	2020	126,843		20	6,342	6,342	38,052	64
65	Cooling Tower Replacement	2020	54,893		20	2,745	2,745	16,470	65
66	Installation of 2 New Bldg Heating & Cooling Pumps	2020	3,154		20	158	158	948	66
67	New Facility Sign	2020	3,506		20	175	175	1,050	67
68	Asphalt Resurface of Facility Parking Lot	2020	22,975		20	1,149	1,149	6,894	68
69	Architecture Fee-Design of New Diavsis Unit	2021	15,375		20	769	769	3,845	69
70	TOTAL (lines 4 thru 69)		\$ 2,936,305	\$		\$ 40,647	\$ 40,647	\$ 2,469,032	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:

01/01/2025

Ending:

12/31/2025

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,936,305	\$		\$ 40,647	\$ 40,647	\$ 2,469,032	1
2	Suburban Elevator-Furnished & Installed Cylinder & Pistons		30,400		15	2,027	2,027	8,108	2
3	Gas Water Heaters		23,288		15	1,553	1,553	6,212	3
4	New Dialysis Unit-Construction, Doors,Electrical		125,850		15	8,390	8,390	33,560	4
5	Remove Existing Ejector Pumps Install 2 New Pumps		17,062		15	1,137	1,137	4,549	5
6	Build New Dialysis Unit		37,844		15	2,523	2,523	10,091	6
7	Lobby Project-New LED Lighting,PVC Flooring,Wall Surfaces		18,915		15	1,261	1,261	3,783	7
8	New Hot Water Heater		22,165		15	1,478	1,478	4,434	8
9	Install New Single Sliding Door in Lobby		18,458		15	1,231	1,231	3,693	9
10	Electrical Work-Upgrade Electrical Panel		3,675		15	245	245	735	10
11	Replace Elevator Cylinder & Aluminum Car Sill		38,900		15	2,593	2,593	7,781	11
12	Lobby Project-New LED Lighting,PVC Flooring,Wall Surfaces		23,889		15	1,593	1,593	3,186	12
13	Part 2 of Project(Line 7)								13
14	Install New Single Sliding Door in Lobby		21,574		15	1,438	1,438	2,876	14
15	Part 2 of Project(Line 10)								15
16	Painting Conference Room		3,100		15	207	207	414	16
17	Relocate fire alarm equipment in new lobby		5,206		15	347	347	694	17
18	Install mixing valves for 2 3 comp sinks		3,700		15	247	247	494	18
19	Removed old strainers and installed new strainers for 3 comp		2,700		15	180	180	360	19
20	sink								20
21	Remove 1. inch galvanized pipe, provide shut off valve, ran		3,850		15	257	257	514	21
22	1.5 copper pipe and fittings and installed 1.5 inch rpz								22
23	Install a new nurses station on first floor	2025	56,000		15				23
24	Rebuild sewer pump		4,500						24
25									25
26									26
27	Financial Statement Depreciation			82,649			(82,649)		27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,397,381	\$ 82,649		\$ 67,352	\$ (15,297)	\$ 2,560,516	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	\$4,140	\$	\$414	\$414		\$1,242	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	1,169,618					1,169,618	73
74								74
75	TOTALS	\$1,173,758	\$	\$414	\$414		\$1,170,860	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$4,695,851	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$82,649	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$67,766	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(14,883)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,731,376	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: _____
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	Allocated rent				8,696			5
6								6
7	TOTAL				\$ 8,696			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			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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

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

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.	/2026	\$
13.	/2027	\$
14.	/2028	\$

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)	\$			

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.)

		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	\$		\$ 101,090	\$		\$ 101,090	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,918			8,918	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			119,596			119,596	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 prescrpts				43,775		43,775	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>Dialysis</u>	39-2					68,430		68,430	12
13	Other (specify): <u>Lab & Xray</u>	39-2					2,565		2,565	13
14	TOTAL			\$		\$ 229,604	\$ 114,770		\$ 344,374	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.

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 448,456	\$ 664,122	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,889,205	2,889,205	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		13,002	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>Escrows</u>		582,651	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,337,661	\$ 4,148,980	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		4,460,625	14
15	Leasehold Improvements, at Historical Cost	1,780,498	2,101,797	15
16	Equipment, at Historical Cost	392,277	876,367	16
17	Accumulated Depreciation (book methods)	(1,584,083)	(6,811,145)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		604,359	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(459,408)	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)	\$ 588,692	\$ 1,032,595	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,926,353	\$ 5,181,575	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 499,481	\$ 499,481	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,077,101	1,077,101	29
30	Accrued Salaries Payable	353,020	353,020	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		442,896	32
33	Accrued Interest Payable		34,244	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Due to related</u>	60,000	20,000	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,989,602	\$ 2,426,742	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,910,911	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)	\$	\$ 11,910,911	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,989,602	\$ 14,337,653	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,936,751	\$ (9,156,078)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,926,353	\$ 5,181,575	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 900,942	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 900,942	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,660,809	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	(1,625,000)	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)	\$ 1,035,809	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)	\$ 1,936,751	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Atrium Health Care Center

0055459

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 14,049,487	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 14,049,487	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	1,856,421	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)	\$ 1,856,421	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	14,438	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 14,438	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 15,920,346	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,340,256	31
32	Health Care	4,751,655	32
33	General Administration	3,201,685	33
	B. Capital Expense		
34	Ownership	1,749,466	34
	C. Ancillary Expense		
35	Special Cost Centers	363,149	35
36	Provider Participation Fee	853,326	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,259,537	40
41	Income before Income Taxes (line 30 minus line 40)**	2,660,809	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 2,660,809	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 1,493,353.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)	8,502,677.00	45
46	MMAI-Medicaid is the Primary Payer	2,285,534.00	46
47	MMAI-Medicare is the Primary Payer		47
48	Private Pay	206,844.00	48
49	Medicare Part A	771,298.00	49
50	Other-(specify) Medicare B	107,864.00	50
51	Other-(specify) Veterans	681,917.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 14,049,487	56

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	3,856	4,032	\$ 239,462	\$ 59.39	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,364	15,252	719,246	47.16	3
4	Licensed Practical Nurses	32,458	35,114	1,328,076	37.82	4
5	CNAs & Orderlies	66,187	70,098	1,753,763	25.02	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,390	7,735	156,948	20.29	10
11	Social Service Workers	11,844	12,439	287,195	23.09	11
12	Dietician					12
13	Food Service Supervisor	2,150	2,222	60,100	27.05	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,198	20,712	458,977	22.16	15
16	Dishwashers					16
17	Maintenance Workers	6,044	6,567	171,512	26.12	17
18	Housekeepers	18,240	20,113	443,006	22.03	18
19	Laundry	7,785	8,537	131,869	15.45	19
20	Administrator	1,990	2,080	129,569	62.29	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,956	8,721	244,467	28.03	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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)	199,462	213,622	\$ 6,124,190 *	\$ 28.67	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 12,546	1-3	35
36	Medical Director	Monthly	26,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	16,062	10-3	39
40	Physical Therapy Consultant	Monthly	15,624	10-3	40
41	Occupational Therapy Consultant	Monthly	9,911	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	Monthly	1,755	10-3	43
44	Activity Consultant	Monthly	1,407	11-3	44
45	Social Service Consultant	Monthly	2,479	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 85,784		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	55	3,047	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	55	\$ 3,047		53

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

** See instructions.

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

0055459

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

XX. GENERAL INFORMATION:

- (1)

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

Yes
- (2)

Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below.
Use the drop down list to identify the association.

Association Name	Amount
HEALTH CARE COUNCIL OF IL (HCCI)	18,560
	18,560

Total
- (3)

List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.

The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

HEALTH CARE COUNCIL OF IL (HCCI)	9,280
	9,280

Total
- (4)

EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE
(2 and 3 combined)

HEALTH CARE COUNCIL OF IL (HCCI)	27,840
	27,840

Total
- (5)

Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 39,063 Line 10
- (6)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (7)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.

\$ 853,326

This amount is to be recorded on line 42 of Schedule V.
- (8)

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.

- (9)

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
- (10)

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.
- (11)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ None

Has any meal income been offset against related costs?

None

Indicate the amount.

\$
- (12)

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.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

100

d. Have vehicle usage logs been maintained?

Yes

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

No

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

No

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.

\$ None
- (13)

Has an audit been performed by an independent certified public accounting firm?

Firm Name:

No
- (14)

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

Yes
- (15)

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.