

		FOR BHF USE					

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**2011**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2011)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0033977</u></p> <p><b>Facility Name:</b> <u>Atrium Health Care Center</u></p> <p><b>Address:</b> <u>1425 Estes Avenue</u> <u>Chicago</u> <u>60626</u>          Number City Zip Code</p> <p><b>County:</b> <u>Cook</u></p> <p><b>Telephone Number:</b> <u>(773) 973-4780</u> <b>Fax #</b> <u>(773) 973-1895</u></p> <p><b>HFS ID Number:</b> _____</p> <p><b>Date of Initial License for Current Owners:</b> <u>00/00/88</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236-1111</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/11</u> to <u>12/31/11</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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) _____ (Date) _____</td> </tr> <tr> <td></td> <td>(Title) _____</td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u></td> </tr> <tr> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # <b>(217) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) _____ (Date) _____		(Title) _____	<b>Paid Preparer</b>	(Signed) _____	(Print Name and Title) <u>Richard S. Sgarlata, C.P.A.</u>	(Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977 Report Period Beginning: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	Private Pay	4 Other	Total		
8	SNF	30,291		3,660	33,951	8	
9	SNF/PED					9	
10	ICF	21,205	30		21,235	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	51,496	30	3,660	55,186	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.50%

D. How many bed-hold days during this year were paid by the Department? 1,088 (Do not include bed-hold days in Section B.)

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

None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES  NO

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 112 and days of care provided 3,548

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2011 Fiscal Year: 12/31/2011

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	270,415	45,122	14,685	330,222		330,222	6,858	337,080		1
2	Food Purchase		242,940		242,940	(37,113)	205,827	(1)	205,825		2
3	Housekeeping	229,196	31,178		260,374		260,374		260,374		3
4	Laundry	73,908	11,167		85,075		85,075		85,075		4
5	Heat and Other Utilities			122,623	122,623		122,623	(1,653)	120,970		5
6	Maintenance	76,063	25,562	46,902	148,527		148,527	12,117	160,644		6
7	Other (specify):*							1,470	1,470		7
8	<b>TOTAL General Services</b>	<b>649,582</b>	<b>355,969</b>	<b>184,210</b>	<b>1,189,761</b>	<b>(37,113)</b>	<b>1,152,648</b>	<b>18,791</b>	<b>1,171,438</b>		<b>8</b>
	<b>B. Health Care and Programs</b>										
9	Medical Director			20,750	20,750		20,750		20,750		9
10	Nursing and Medical Records	1,714,832	58,713	13,557	1,787,102		1,787,102		1,787,102		10
10a	Therapy	22,506		120	22,626		22,626		22,626		10a
11	Activities	77,943	4,167	2,408	84,518		84,518		84,518		11
12	Social Services	103,976	41,298	3,374	148,648		148,648		148,648		12
13	CNA Training										13
14	Program Transportation			533	533		533		533		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	<b>1,919,257</b>	<b>104,178</b>	<b>40,742</b>	<b>2,064,177</b>		<b>2,064,177</b>		<b>2,064,177</b>		<b>16</b>
	<b>C. General Administration</b>										
17	Administrative	106,511		402,050	508,561		508,561	(295,468)	213,093		17
18	Directors Fees										18
19	Professional Services			35,664	35,664	(855)	34,809	728	35,537		19
20	Dues, Fees, Subscriptions & Promotions			28,437	28,437		28,437	(5,349)	23,088		20
21	Clerical & General Office Expenses	93,048	38,471	241,743	373,262		373,262	(173,257)	200,005		21
22	Employee Benefits & Payroll Taxes			431,114	431,114	37,113	468,227		468,227		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,600	1,600		1,600	225	1,825		24
25	Other Admin. Staff Transportation			2,788	2,788		2,788	4,065	6,853		25
26	Insurance-Prop.Liab.Malpractice			103,275	103,275		103,275	1,815	105,090		26
27	Other (specify):*							46,701	46,701		27
28	<b>TOTAL General Administration</b>	<b>199,559</b>	<b>38,471</b>	<b>1,246,671</b>	<b>1,484,701</b>	<b>36,258</b>	<b>1,520,959</b>	<b>(420,540)</b>	<b>1,100,419</b>		<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	<b>2,768,398</b>	<b>498,618</b>	<b>1,471,623</b>	<b>4,738,639</b>	<b>(855)</b>	<b>4,737,784</b>	<b>(401,750)</b>	<b>4,336,034</b>		<b>29</b>

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name &amp; ID Number

Atrium Health Care Center

#0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

## 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			39,989	39,989		39,989	64,197	104,186			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			27,312	27,312		27,312	194,946	222,258			32
33	Real Estate Taxes			218,756	218,756	855	219,611	6,035	225,646			33
34	Rent-Facility & Grounds			2,545,000	2,545,000		2,545,000	(2,545,000)	(0)			34
35	Rent-Equipment & Vehicles			312	312		312	12,615	12,927			35
36	Other (specify):*							(0)	(0)			36
37	<b>TOTAL Ownership</b>			2,831,369	2,831,369	855	2,832,224	(2,267,207)	565,017			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,796	255,649	349,445		349,445		349,445			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,600	87,600		87,600		87,600			42
43	Other (specify):*			1,458	1,458		1,458	(1,458)	(0)			43
44	<b>TOTAL Special Cost Centers</b>		93,796	344,707	438,503		438,503	(1,458)	437,045			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,768,398	592,414	4,647,699	8,008,511		8,008,511	(2,670,415)	5,338,096			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

# **0033977**

Report Period Beginning:

**01/01/11**

Ending:

**12/31/11**

**VI. ADJUSTMENT DETAIL**

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

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,510)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(53,212)	30		9
10	Interest and Other Investment Income	(8,946)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220,968)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,156)	20		28
29	Other-Attach Schedule	(61,112)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (348,906)		\$	30

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,321,509)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (2,321,509)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (2,670,415)		37

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/11

Ending: 12/31/11

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Miscellaneous Income	\$ (5,025)	21	1
2	Marketing Expense	(1,458)	43	2
3	Replacement Income Tax	(12,835)	21	3
4	COPE Dues	(4,193)	20	4
5	Additional R&M	1,700	06	5
6	Building Co. - Amortization	(9,026)	36	6
7	Building Co. - Illinois Replacement Tax	(28,700)	21	7
8	Building Co. - Accounting Fees	(975)	19	8
9	Non-Allowable Legal	(600)	19	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	<b>Total</b>	(61,112)		49

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/11

Ending: 12/31/11

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

		\$		
50				1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
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97				48
98				49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				6,858								6,858	1
2	Food Purchase	(1)											(1)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(3,510)		1,857									(1,653)	5
6	Maintenance	1,700		3,876	6,541								12,117	6
7	Other (specify):*				1,470								1,470	7
8	<b>TOTAL General Services</b>	<b>(1,811)</b>		<b>5,733</b>	<b>14,869</b>								<b>18,791</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>													<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			(367,996)	72,528								(295,468)	17
18	Directors Fees													18
19	Professional Services	(1,575)	975	1,018		310							728	19
20	Fees, Subscriptions & Promotions	(5,349)											(5,349)	20
21	Clerical & General Office Expenses	(267,528)	28,700	65,570		1							(173,257)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			225									225	24
25	Other Admin. Staff Transportation			4,065									4,065	25
26	Insurance-Prop.Liab.Malpractice			1,497		318							1,815	26
27	Other (specify):*			42,365	4,336								46,701	27
28	<b>TOTAL General Administration</b>	<b>(274,452)</b>	<b>29,675</b>	<b>(253,256)</b>	<b>76,864</b>	<b>628</b>							<b>(420,540)</b>	<b>28</b>
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(276,263)</b>	<b>29,675</b>	<b>(247,523)</b>	<b>91,733</b>	<b>628</b>							<b>(401,750)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(53,212)	114,375			3,035							64,197	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(8,946)	200,090			3,802							194,946	32
33	Real Estate Taxes					6,035							6,035	33
34	Rent-Facility & Grounds		(2,545,000)	18,277		(18,277)							(2,545,000)	34
35	Rent-Equipment & Vehicles			12,615									12,615	35
36	Other (specify):*	(9,026)	9,026										(0)	36
37	<b>TOTAL Ownership</b>	<b>(71,185)</b>	<b>(2,221,509)</b>	<b>30,892</b>		<b>(5,405)</b>							<b>(2,267,207)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,458)											(1,458)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(1,458)</b>											<b>(1,458)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(348,906)</b>	<b>(2,191,834)</b>	<b>(216,631)</b>	<b>91,733</b>	<b>(4,777)</b>							<b>(2,670,415)</b>	<b>45</b>

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 6-Supplemental		See 6-Supplemental		See 6-Supplemental		
				Atrium Healthcare Ltd. Partnership		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	34 Rent Income	\$ 2,545,000	Atrium Healthcare Center Ltd. Partnership		\$	(2,545,000)	1
2	V	32 Mortgage Interest		Atrium Healthcare Center Ltd. Partnership		200,090	200,090	2
3	V	30 Depreciation		Atrium Healthcare Center Ltd. Partnership		114,375	114,375	3
4	V	36 Amortization		Atrium Healthcare Center Ltd. Partnership		9,026	9,026	4
5	V	21 Illinois Replacement Tax		Atrium Healthcare Center Ltd. Partnership		28,700	28,700	5
6	V	19 Accounting Fees		Atrium Healthcare Center Ltd. Partnership		975	975	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,545,000			\$ 353,166	\$ * (2,191,834)	14

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	STAYCARE MANAGEMENT, LTD.	100.00%	\$ 1,857	\$ 1,857
16	V	6 REPAIRS AND MAINT.				3,876	3,876
17	V	17 ADMIN. SALARY				34,054	34,054
18	V	19 PROFESSIONAL FEES				2,977	2,977
19	V	21 CLERICAL & GENERAL				65,570	65,570
20	V	24 SEMINARS				225	225
21	V	25 ADMIN. STAFF TRAVEL				4,065	4,065
22	V	26 INSURANCE				1,497	1,497
23	V	27 EMPLOYEE BENEFITS				42,365	42,365
24	V	34 BUILDING RENT				18,277	18,277
25	V	35 EQUIPMENT RENTAL				12,615	12,615
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V	17 MANAGEMENT FEES	402,050	STAYCARE MANAGEMENT, LTD.			(402,050)
33	V	19 CONSULTING FEE	1,959	STAYCARE MANAGEMENT, LTD.			(1,959)
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 404,009			\$ 187,378	\$ * (216,631)

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	1 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 3,429	\$	3,429	15
16	V	1 DIET. COMP - D. WENGROW				3,429		3,429	16
17	V	6 MAINT. COMP. - NON-OWNER				6,541		6,541	17
18	V	7 EMP. BEN. - S. WEBSTER				349		349	18
19	V	7 EMP. BEN. - D. WENGROW				349		349	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER				772		772	20
21	V	17 ADMIN. COMP - H. WENGROW				15,385		15,385	21
22	V	17 ADMIN. COMP - J. WEBSTER				57,143		57,143	22
23	V								23
24	V	27 EMP. BEN. - H. WENGROW				918		918	24
25	V	27 EMP. BEN. - J. WEBSTER				3,418		3,418	25
26	V	27 EMP. BEN. - DAVID WENGROW							26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	<b>Total</b>		\$			\$ 91,733	\$ *	91,733	39

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

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	19 PROFESSIONAL FEES	\$	DOUBLE YOU REALTY, LLC	100.00%	\$ 310	\$	310	15
16	V	21 OFFICE EXPENSE		DOUBLE YOU REALTY, LLC		1		1	16
17	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		318		318	17
18	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		3,035		3,035	18
19	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		3,802		3,802	19
20	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		6,035		6,035	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34 RENT	18,277	DOUBLE YOU REALTY, LLC				(18,277)	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		\$ 18,277			\$ 13,500	\$ *	(4,777)	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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



**VII. RELATED PARTIES (continued)**

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

**VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.  YES  NO

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	<b>Total</b>		\$			\$	\$ *	39

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

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ABRAHAM MIKEL	0.625%	ABBINGTON REHAB & NURSING CENTER, LTD.	ROSELLE	ATRIUM HEALTHCARE LTD. P	LINCOLNWOOD	BUILDING CO.	1
2	ABRAHAM STERN	3.125%	ARBOUR HEALTH CARE CENTER, LTD.	CHICAGO	DOUBLE YOU REALTY	LINCOLNWOOD	BUILDING COMPANY	2
3	ARTHUR ROTHBLATT	0.422%	HICKORY NURSING PAVILION, INC.	HICKORY HILLS	STAYCARE MANAGEMENT	LINCOLNWOOD	MANAGEMENT, BOOKKEE	3
4	BERNARD FRUCHTER	0.388%	RIDGEVIEW REHAB & NURSING CENTER, LLC	CHICAGO				4
5	BETTE COHEN	0.208%	ZIKAINIM, INC. D/B/A ALL AMERICAN NURSING HOME	CHICAGO				5
6	CARY BUXBAUM	0.422%						6
7	DAVID WENGROW	1.250%						7
8	DINA WENGROW	1.250%						8
9	EDWARD G ROTHBLATT ADMIN TRUST	0.422%						9
10	ELI WEBSTER	1.250%						10
11	GAIL GOODSITE REVOCABLE TRUST	0.388%						11
12	GARRY CHANKIN	0.422%						12
13	HOWARD WENGROW	30.938%						13
14	JAY WENGROW	1.250%						14
15	JEFFREY J. WEBSTER	29.688%						15
16	JEFFREY SINGER	0.422%						16
17	MARVIN FOX	0.422%						17
18	MYRNA HILL	0.422%						18
19	NOSHIR DARUWALLA	0.422%						19
20	RICHARD SGARLATA	0.422%						20
21	ROBERT A. ROSE	0.422%						21
22	SHERRY WARSO	18.750%						22
23	SHIMON WEBSTER	1.250%						23
24	STEVE SILBERMAN	0.422%						24
25	SUSAN STERN	3.125%						25
26	YAAKOV MIKEL	0.625%						26
27	YERUCHOM LEVOVITZ	1.250%						27
28								28
29								29
30								30

**VII. RELATED PARTIES**

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number

Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

## 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	Jeff Webster	Owner	Administrative	29.69%	See Attached	20	28.57%	Alloc. Salary	\$ 57,143	17-7	1
2	Howard Wengrow	Owner	Administrative	30.94%	See Attached	5	7.69%	Alloc. Salary	15,385	17-7	2
3	Sara Webster	Relative	Dietary	0%	See Attached	1.7	33.93%	Alloc. Salary	3,429	01-07	3
4	Deborah Wengrow	Relative	Dietary	0%	See Attached	1.7	33.93%	Alloc. Salary	3,429	01-07	4
5	Dina Wengrow	Owner	Clerical	1.25%	See Attached	1.49	21.17%	Alloc. Salary	1,736	21-7	5
6											6
7											7
8											8
9	When applicable, the amounts reported on this page have been adjusted from the actual costs										9
10	to reflect only amounts anticipated to be considered allowable by the Il. Dept of HFS.										10
11											11
12											12
13								TOTAL	\$ 81,122		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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PATIENT DAYS	222,828	6	\$ 7,499	\$ 55,186	\$ 1,857	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	222,828	6	15,652	55,186	3,876	2	
3	17	ADMIN. SALARY	PATIENT DAYS	222,828	6	137,500	137,500	55,186	34,054	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	222,828	6	12,019	55,186	2,977	4	
5	21	CLERICAL & GENERAL	PATIENT DAYS	222,828	6	264,756	226,006	55,186	65,570	5
6	24	SEMINARS	PATIENT DAYS	222,828	6	910	55,186	225	6	
7	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	222,828	6	16,414	55,186	4,065	7	
8	26	INSURANCE	PATIENT DAYS	222,828	6	6,045	55,186	1,497	8	
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	222,828	6	171,058	55,186	42,365	9	
10	34	BUILDING RENT	PATIENT DAYS	222,828	6	73,800	55,186	18,277	10	
11	35	EQUIPMENT RENTAL	PATIENT DAYS	222,828	6	50,938	55,186	12,615	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					\$ 756,591	\$ 363,506	\$ 187,378	25	

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIET. COMP - S. WEBSTER	AVG. HOURS WORKED	5	4	10,104	2	3,429	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	10,104	2	3,429	2
3	6	MAINT. COMP. - NON-OWNER	AVG. HOURS WORKED	40	6	26,410	10	6,541	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,028	2	349	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	1,028	2	349	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	3,116	10	772	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	200,000	5	15,385	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	200,000	20	57,143	8
9									9
10	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	11,928	5	918	10
11	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	11,964	20	3,418	11
12	27	EMP. BEN. - DAVID WENGROV	AVG. HOURS WORKED	40	1	658			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					\$ 476,340	\$ 446,618	\$ 91,733	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	222,828	6	\$ 1,250	\$ 55,186	\$ 310	1
2	21	OFFICE EXPENSE	PATIENT DAYS	222,828	6	3	55,186	1	2
3	26	INSURANCE	PATIENT DAYS	222,828	6	1,283	55,186	318	3
4	30	DEPRECIATION	PATIENT DAYS	222,828	6	12,254	55,186	3,035	4
5	32	INTEREST EXPENSE	PATIENT DAYS	222,828	6	15,350	55,186	3,802	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	222,828	6	24,370	55,186	6,035	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					\$ 54,510	\$	\$ 13,500	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977 Report Period Beginning: 01/01/11 Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending: 12/31/11

**VIII. ALLOCATION OF INDIRECT COSTS**

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

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

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

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

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT





Facility Name & ID Number

Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

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

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

1	2	3	4	5	6	7	8	9	10											
										Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	<b>TOTAL Long-Term</b>										7									
<b>Working Capital</b>																				
8										8										
9										9										
10										10										
11										11										
12										12										
13										13										
14	<b>TOTAL Working Capital</b>										14									
<b>B. Non-Facility Related*</b>																				
15										15										
16										16										
17										17										
18										18										
19										19										
20	<b>TOTAL Non-Facility Related</b>										20									

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

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

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

(See instructions.)

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

**B. Real Estate Taxes**

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

1. Real Estate Tax accrual used on 2010 report.	\$	<b>212,052</b>	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.)	\$	<b>216,186</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>4,134</b>	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>220,658</b>	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. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$	<b>855</b>	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. <b>TOTAL REFUND \$ 2,558 For 2007 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>225,647</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2006	<b>170,201</b>	8
	2007	<b>168,384</b>	9
	2008	<b>170,073</b>	10
	2009	<b>201,383</b>	11
	2010	<b>210,150</b>	12

**2011 Accrual = \$210,150 x 1.05 = \$220,658**

**Allocated from Double You = \$6,035**

**Beginning Accrual Adjusted**

**We did not offset the refund since it was not for a R/E bill which was used to set a reimbursement rate.**

<b>FOR BHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 2010	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**NOTES:**

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

**SEE ACCOUNTANTS' COMPILATION REPORT**



# 2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Atrium Health Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0033977

CONTACT PERSON REGARDING THIS REPORT \_\_\_\_\_

TELEPHONE ( ) \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

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

**B. Real Estate Tax Cost Allocations**

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

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

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

**X. BUILDING AND GENERAL INFORMATION:**

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

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

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

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
 List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

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

Nature of Costs:

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

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>26,895</u>	<u>1975</u>	<u>\$ 124,712</u>	<u>1</u>
2	<u>Allocated from Double You</u>			<u>12,383</u>	<u>2</u>
3	<b>TOTALS</b>	<b>26,895</b>		<b>\$ 137,095</b>	<b>3</b>

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	160		1972	\$ 574,854	\$ 114,375	33	\$ 26,504	\$ (87,871)	\$ 839,894	4
5			1972	344,971		20				5
6										6
7										7
8										8
<b>Improvement Type**</b>										
9	Various		1972	50,343		20				9
10	Various		1974	12,941		20				10
11	Various		1977	46,500		20				11
12	Various		1978	23,362		20				12
13	Various		1979	11,676		20			1,354	13
14	Various		1980	12,652		20			580	14
15	Various		1981	4,095		20			393	15
16	Various		1982	1,310		20			1,310	16
17	Various		1989	42,200		20			35,799	17
18	Various		1992	16,375		20	819	819	15,117	18
19	Various		1993	26,090		20	1,305	1,305	22,565	19
20	Various		1995	32,183		20	1,609	1,609	25,968	20
21	Various		1996	71,604		20	3,580	3,580	55,792	21
22	Various		1997	52,684		20	2,634	2,634	38,579	22
23	Various		1998	131,108		20	6,555	6,555	89,471	23
24	Various		1999	15,353		20	768	768	9,657	24
25	Various		2000	71,157		20	2,616	2,616	31,752	25
26	Various		2001	13,010		20	651	651	6,947	26
27	Various		2002	6,846		20	685	685	6,556	27
28	Various		2003	60,162		20	3,663	3,663	44,448	28
29	Various		2004	7,347		20	511	511	3,872	29
30	Various		2005	24,381		20	2,118	2,118	13,842	30
31	Various		2006	41,619		20	3,881	3,881	21,111	31
32	Various		2007	6,765		20	338	338	1,663	32
33										33
34										34
35										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

SEE ACCOUNTANTS' COMPILATION REPORT

**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		\$	\$		\$	\$	\$
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68		123,849	3,035		3,309	274	29,535
69			39,989			(39,989)	
70		\$ 1,825,437	\$ 157,399		\$ 61,545	\$ (95,854)	\$ 1,296,204

SEE ACCOUNTANTS' COMPILATION REPORT

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



Facility Name &amp; ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

## XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	<b>Totals from Page 12A, Carried Forward</b>		\$ 1,825,437	\$ 157,399		\$ 61,545	\$ (95,854)	\$ 1,296,204	1
2	Econocare, Inc. 31412 - Floors/Wallcovering/Window Treatments	2008	23,137		20	3,305	3,305	12,946	2
3	J. Franco Wrought Iron Fencing & Maintenance	2008	2,760		20	276	276	989	3
4	Advanced Generator	2008	2,579		20	129	129	451	4
5	Econocare, Inc. - Elevator Remodel: Walls/Floor/Ceiling/Light	2008	16,398		20	1,640	1,640	5,466	5
6	Long Elevator Ma10130349	2008	3,142		20	157	157	511	6
7	35 New Doors And Crown Molding	2009	34,435		20	3,444	3,444	9,757	7
8	Corner Guards, Wood Blinds, Curtains, Curtain Tracks, And Ren	2009	14,288		20	1,429	1,429	3,810	8
9	Aluminum Identification Signage/Exterior	2009	6,955		20	695	695	1,855	9
10	Wallcovering Field And Accent For Therapy Room	2009	6,676		20	668	668	1,892	10
11	Removal And Installation Of Wallcovering	2009	19,149		20	1,915	1,915	4,309	11
12	Installing Wallcovering And Wallpaper	2009	5,809		20	581	581	1,404	12
13	Freezer	2010	3,405		20	341	341	511	13
14	Flooring, Baseboard, Paint, Wallpaper, Cabinetry, Door	2010	12,755		20	1,276	1,276	1,807	14
15	Crown Molding, Doors	2010	31,695		20	3,170	3,170	4,490	15
16	Static Fire Dampers	2010	2,788		20	279	279	325	16
17	Fire Sprinkler Work	2010	2,950		20	148	148	234	17
18	Motor / Blower Units	2010	2,758		20	138	138	276	18
19	Fire Sprinkler	2011	6,438		20	429	429	429	19
20	Water Heater	2011	13,172		20	768	768	768	20
21	Kitchen Walk-In Cooler	2011	2,995		20	100	100	100	21
22	Walk-In Cooler	2011	2,561		20	213	213	213	22
23	Wall Covering	2011	10,115		20	169	169	169	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	<b>TOTAL (lines 1 thru 33)</b>		\$ 2,052,396	\$ 157,399		\$ 82,812	\$ (74,587)	\$ 1,348,913	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,052,396	\$ 157,399		\$ 82,812	\$ (74,587)	\$ 1,348,913	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,052,396	\$ 157,399		\$ 82,812	\$ (74,587)	\$ 1,348,913	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,052,396	\$ 157,399		\$ 82,812	\$ (74,587)	\$ 1,348,913	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,052,396	\$ 157,399		\$ 82,812	\$ (74,587)	\$ 1,348,913	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1		\$ 2,052,396	\$ 157,399		\$ 82,812	\$ (74,587)	\$ 1,348,913	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34	TOTAL (lines 1 thru 33)	\$ 2,052,396	\$ 157,399		\$ 82,812	\$ (74,587)	\$ 1,348,913	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	<b>Building Company Information</b>								1
2	<b>Buildings:</b>								2
3									3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*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	<b>Related Party Information</b>		\$	\$		\$	\$	\$	1
2	<b>Buildings:</b>								2
3	<b>Allocated from Double You</b>	2003	118,366	3,035	39	3,035		27,189	3
4									4
5									5
6									6
7									7
8	<b>Leasehold Improvements:</b>								8
9	<b>Allocated from Stavcare</b>	2003	5,483		20	274	274	2,346	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1								1	
2								2	
3								3	
4								4	
5								5	
6								6	
7								7	
8								8	
9								9	
10								10	
11								11	
12								12	
13								13	
14								14	
15								15	
16								16	
17								17	
18								18	
19								19	
20								20	
21								21	
22								22	
23								23	
24								24	
25								25	
26								26	
27								27	
28								28	
29								29	
30								30	
31								31	
32								32	
33								33	
34	TOTAL (12H & 12I lines 1 thru 33)		\$ 123,849	\$ 3,035		\$ 3,309	\$ 274	\$ 29,535	34

SEE ACCOUNTANTS' COMPILATION REPORT

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



Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

**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	\$ 143,939	\$	\$ 19,256	\$ 19,256	10	\$ 117,779	71
72	Current Year Purchases	18,852		1,425	1,425	10	1,425	72
73	Fully Depreciated Assets	427,512				10	427,512	73
74								74
75	<b>TOTALS</b>	\$ 590,303	\$	\$ 20,681	\$ 20,681		\$ 546,716	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	2010	\$ 6,934	\$	\$ 693	\$ 693	5	\$ 6,934	76
77										77
78										78
79										79
80	<b>TOTALS</b>			\$ 6,934	\$	\$ 693	\$ 693		\$ 6,934	80

**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)	\$ 2,786,728	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 157,399	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 104,187	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (53,212)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,902,563	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	<b>TOTALS</b>	\$	\$	\$	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.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.  YES  NO

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

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

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

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

**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: \$ 312 Description: See Attached Schedule

(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	<u>Allocated from Staycare</u>		\$	\$ <u>12,615</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>12,615</u>	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. \_\_\_\_\_ /2012 \$ \_\_\_\_\_

13. \_\_\_\_\_ /2013 \$ \_\_\_\_\_

14. \_\_\_\_\_ /2014 \$ \_\_\_\_\_

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

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

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

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

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

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**C. CONTRACTUAL INCOME**

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

\$

**D. NUMBER OF CNAs TRAINED**

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Staff		Outside Practitioner (other than consultant)							
			Units of Service	Cost	Units	Cost						
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	117,356	\$		\$	117,356	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				33,274				33,274	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				105,019				105,019	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescrpts					93,796			93,796	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Other (specify): _____											12
13	Other (specify): <u>See Supplemental</u>											13
14	TOTAL			\$		\$	255,649	\$	93,796	\$	349,445	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning: 01/01/11

Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11

(last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
<b>A. Current Assets</b>				
1	Cash on Hand and in Banks	\$ 249,686	\$ 696,612	1
2	Cash-Patient Deposits	128	128	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,220,625	2,220,625	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	142,219	142,219	6
7	Other Prepaid Expenses	3,856	3,856	7
8	Accounts Receivable (owners or related parties)	1,304,982	1,304,982	8
9	Other(specify): <u>See Attached Schedule</u>		(1,304,982)	9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 3,921,496	\$ 3,063,440	10
<b>B. Long-Term Assets</b>				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		219,382	13
14	Buildings, at Historical Cost		4,460,623	14
15	Leasehold Improvements, at Historical Cost	654,660	654,660	15
16	Equipment, at Historical Cost	307,372	787,372	16
17	Accumulated Depreciation (book methods)	(524,654)	(3,106,295)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>See Attached Schedule</u>		45,131	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 437,378	\$ 3,060,873	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 4,358,874	\$ 6,124,313	25

		1	2	
		Operating	After Consolidation*	
<b>C. Current Liabilities</b>				
26	Accounts Payable	\$ 201,380	\$ 201,379	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	855,000	855,000	29
30	Accrued Salaries Payable	135,442	135,442	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,437	5,437	31
32	Accrued Real Estate Taxes(Sch.IX-B)	220,658	220,658	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
<b>Other Current Liabilities(specify):</b>				
36	<u>See Attached Schedule</u>	7,080	7,080	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,424,997	\$ 1,424,996	38
<b>D. Long-Term Liabilities</b>				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,912,101	40
41	Bonds Payable			41
42	Deferred Compensation			42
<b>Other Long-Term Liabilities(specify):</b>				
43	<u>See Attached Schedule</u>			43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,912,101	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,424,997	\$ 7,337,097	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 2,933,877	\$ (1,212,784)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 4,358,874	\$ 6,124,313	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		1 Total	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>2,451,455</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<u>Rounding</u>	<b>6</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>2,451,461</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>482,416</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>482,416</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>2,933,877</b>	<b>24</b> *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/11Ending: 12/31/11

**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	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 8,226,020	1
2	Discounts and Allowances for all Levels	(663,827)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 7,562,193</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	573,690	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 573,690</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	104,639	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,455	19
20	Radiology and X-Ray		20
21	Other Medical Services	11,925	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 121,019</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	8,946	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$ 8,946</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<u>See Supplemental Schedule</u>	225,079	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 225,079</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,490,927</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,189,761	31
32	Health Care	2,064,177	32
33	General Administration	1,484,701	33
<b>B. Capital Expense</b>			
34	Ownership	2,831,369	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	350,903	35
36	Provider Participation Fee	87,600	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 8,008,511</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>482,416</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ 482,416</b>	<b>43</b>

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

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Atrium Health Care Center

# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11

**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	2,529	2,695	\$ 95,654	\$ 35.49	1
2	Assistant Director of Nursing	1,186	1,263	44,129	34.94	2
3	Registered Nurses	10,625	11,587	343,672	29.66	3
4	Licensed Practical Nurses	19,950	21,090	499,306	23.68	4
5	CNAs & Orderlies	48,691	52,143	507,677	9.74	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,872	2,083	22,506	10.80	8
9	Activity Director	1,711	1,951	22,909	11.74	9
10	Activity Assistants	5,381	5,786	55,034	9.51	10
11	Social Service Workers	7,770	8,338	103,976	12.47	11
12	Dietician					12
13	Food Service Supervisor	1,995	2,171	36,033	16.60	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,011	21,799	234,382	10.75	15
16	Dishwashers					16
17	Maintenance Workers	5,021	5,342	76,063	14.24	17
18	Housekeepers	24,326	26,197	229,196	8.75	18
19	Laundry	4,593	5,219	73,908	14.16	19
20	Administrator	1,976	2,080	106,511	51.21	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,920	8,493	93,048	10.96	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	1,621	1,901	29,085	15.30	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,724	6,358	195,310	30.72	33
34	TOTAL (lines 1 - 33)	172,902	186,496	\$ 2,768,399 *	\$ 14.84	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 10,852	01-03	35
36	Medical Director	Monthly	20,750	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,045	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1	120	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	43	2,408	11-03	44
45	Social Service Consultant	25	3,374	12-03	45
46	Other(specify)				46
47	<u>Religious Services</u>	Monthly	3,833	01-03	47
48					48
49	TOTAL (lines 35 - 48)	69	\$ 54,894		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

SEE ACCOUNTANTS' COMPILATION REPORT





**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	<b>TOTALS</b>		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/11

Ending:

12/31/11**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC - \$16,000 IAHC - \$640
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 21,243 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 87,600  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 37,113 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? No  
Attach invoices and a summary of services for all architect and appraisal fees.

**SEE ACCOUNTANTS' COMPILATION REPORT**