

Facility Name & ID Number Atrium Health Care Center

0033977 Report Period Beginning: 01/01/09 Ending: 12/31/09

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 Total	
		3 Medicaid Recipient	4 Private Pay	Other	Total		
8	SNF	21,986	164	4,841	26,991	8	
9	SNF/PED					9	
10	ICF	28,131	194	28	28,353	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	50,117	358	4,869	55,344	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.77%

D. How many bed-hold days during this year were paid by the Department? 1,840 (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 56 and days of care provided 4,841

Medicare Intermediary Wisconsin Physician Services

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2009 Fiscal Year: 12/31/2009

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

Facility Name & ID Number Atrium Health Care Center # 0033977 Report Period Beginning: 01/01/09 Ending: 12/31/09

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	264,468	59,150	12,995	336,613		336,613	6,858	343,471		1
2	Food Purchase		224,474		224,474	(34,420)	190,055	(15)	190,040		2
3	Housekeeping	230,756	34,484		265,240		265,240		265,240		3
4	Laundry	73,845	8,073		81,918		81,918		81,918		4
5	Heat and Other Utilities			111,454	111,454		111,454	(313)	111,141		5
6	Maintenance	47,974	20,640	38,973	107,587		107,587	9,139	116,726		6
7	Other (specify):*							1,401	1,401		7
8	TOTAL General Services	617,043	346,821	163,422	1,127,286	(34,420)	1,092,867	17,070	1,109,937		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	1,664,908	56,401	6,720	1,728,029		1,728,029	(600)	1,727,429		10
10a	Therapy	21,128		339	21,467		21,467		21,467		10a
11	Activities	68,277	4,083	2,394	74,754		74,754		74,754		11
12	Social Services	81,507	31,410	1,611	114,528		114,528		114,528		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,835,820	91,894	29,064	1,956,778		1,956,778	(600)	1,956,178		16
	C. General Administration										
17	Administrative	123,796		378,000	501,796		501,796	(274,543)	227,253		17
18	Directors Fees										18
19	Professional Services			42,196	42,196	(927)	41,269	2,107	43,376		19
20	Dues, Fees, Subscriptions & Promotions			30,931	30,931		30,931	(12,360)	18,571		20
21	Clerical & General Office Expenses	58,287	27,147	423,863	509,297		509,297	(354,342)	154,955		21
22	Employee Benefits & Payroll Taxes			448,442	448,442	34,420	482,862		482,862		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,068	1,068		1,068	379	1,447		24
25	Other Admin. Staff Transportation			2,031	2,031		2,031	3,218	5,249		25
26	Insurance-Prop.Liab.Malpractice			112,663	112,663		112,663	1,988	114,651		26
27	Other (specify):*							41,271	41,271		27
28	TOTAL General Administration	182,083	27,147	1,439,194	1,648,424	33,493	1,681,917	(592,283)	1,089,634		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,634,946	465,862	1,631,680	4,732,488	(927)	4,731,561	(575,812)	4,155,749		29

*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.

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			28,623	28,623		28,623	70,794	99,417			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,398	24,398		24,398	205,382	229,780			32
33	Real Estate Taxes			193,956	193,956	927	194,883	7,231	202,114			33
34	Rent-Facility & Grounds			2,500,000	2,500,000		2,500,000	(2,500,000)				34
35	Rent-Equipment & Vehicles							12,419	12,419			35
36	Other (specify):*											36
37	TOTAL Ownership			2,746,977	2,746,977	927	2,747,904	(2,204,174)	543,729			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		126,698	363,373	490,071		490,071		490,071			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):*											43
44	TOTAL Special Cost Centers		126,698	450,973	577,671		577,671		577,671			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,634,946	592,560	4,829,630	8,057,136	0	8,057,136	(2,779,987)	5,277,149			45

THE TOTAL FOR COLUMN 5 MUST BE ZERO,PLEASE CORRECT

*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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,148)	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	(47,411)	30		9
10	Interest and Other Investment Income	(21,328)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(15)	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	(404,929)	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	(6,904)	20		28
29	Other-Attach Schedule	(46,215)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (528,950)		\$	30

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

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,251,037)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,251,037)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,779,987)		37

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

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

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

BHF USE ONLY							
48		49		50		51	

SEE ACCOUNTANTS' COMPILATION REPORT

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Pharmacy - VA	\$ (600)	10	1
2	Prior Year Legal	(10)	19	2
3	COPE Dues	(5,456)	20	3
4	Parking Income	(3,737)	21	4
5	BLDG - Amortization	(9,026)	36	5
6	BLDG - Replacement Tax	(19,509)	21	6
7	Replacement Tax	(7,876)	21	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(46,215)		49

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/09

Ending: 12/31/09

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
50		\$	1
51			2
52			3
53			4
54			5
55			6
56			7
57			8
58			9
59			10
60			11
61			12
62			13
63			14
64			15
65			16
66			17
67			18
68			19
69			20
70			21
71			22
72			23
73			24
74			25
75			26
76			27
77			28
78			29
79			30
80			31
81			32
82			33
83			34
84			35
85			36
86			37
87			38
88			39
89			40
90			41
91			42
92			43
93			44
94			45
95			46
96			47
97			48
98			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	(15)											(15)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(2,148)		1,835									(313)	5
6	Maintenance			2,170	6,969								9,139	6
7	Other (specify):*				1,401								1,401	7
8	TOTAL General Services	(2,163)		4,005	15,228								17,070	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(600)											(600)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs	(600)											(600)	16
	C. General Administration													
17	Administrative			(345,257)	70,714								(274,543)	17
18	Directors Fees													18
19	Professional Services	(10)		1,727		390							2,107	19
20	Fees, Subscriptions & Promotions	(12,360)											(12,360)	20
21	Clerical & General Office Expenses	(436,051)	19,509	62,200									(354,342)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			379									379	24
25	Other Admin. Staff Transportation			3,218									3,218	25
26	Insurance-Prop.Liab.Malpractice			1,516		472							1,988	26
27	Other (specify):*			36,507	4,764								41,271	27
28	TOTAL General Administration	(448,422)	19,509	(239,710)	75,478	862							(592,283)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(451,184)	19,509	(235,705)	90,706	862							(575,812)	29

STATE OF ILLINOIS

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/09

Ending:

Summary B

12/31/09

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(47,411)	114,375			3,830							70,794	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(21,328)	220,616			6,094							205,382	32
33	Real Estate Taxes					7,231							7,231	33
34	Rent-Facility & Grounds		(2,500,000)	19,512		(19,512)							(2,500,000)	34
35	Rent-Equipment & Vehicles			12,419									12,419	35
36	Other (specify):*	(9,026)	9,026											36
37	TOTAL Ownership	(77,765)	(2,155,983)	31,931		(2,357)							(2,204,174)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(528,950)	(2,136,474)	(203,774)	90,706	(1,495)							(2,779,987)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

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

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	\$ 2,500,000	Atrium Healthcare Ltd. Partnership	100.00%	\$	\$ (2,500,000)	1
2	V	32 Mortgage Interest		Atrium Healthcare Ltd. Partnership		220,616	220,616	2
3	V	30 Depreciation		Atrium Healthcare Ltd. Partnership		114,375	114,375	3
4	V	36 Amortization		Atrium Healthcare Ltd. Partnership		9,026	9,026	4
5	V	21 Replacement Tax		Atrium Healthcare Ltd. Partnership		19,509	19,509	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,500,000			\$ 363,526	\$ * (2,136,474)	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%	\$ 1,835	\$	1,835	15
16	V	6 REPAIRS AND MAINT.		STAYCARE MANAGEMENT, LTD.		2,170		2,170	16
17	V	17 ADMIN. SAL.-NON OWNER		STAYCARE MANAGEMENT, LTD.		32,743		32,743	17
18	V	19 PROFESSIONAL FEES		STAYCARE MANAGEMENT, LTD.		1,727		1,727	18
19	V	20 DUES, SUBSCRIPTIONS		STAYCARE MANAGEMENT, LTD.					19
20	V	21 CLERICAL & GENERAL		STAYCARE MANAGEMENT, LTD.		62,200		62,200	20
21	V	24 SEMINARS		STAYCARE MANAGEMENT, LTD.		379		379	21
22	V	25 ADMIN. STAFF TRAVEL		STAYCARE MANAGEMENT, LTD.		3,218		3,218	22
23	V	26 INSURANCE		STAYCARE MANAGEMENT, LTD.		1,516		1,516	23
24	V	27 EMPLOYEE BENEFITS		STAYCARE MANAGEMENT, LTD.		36,507		36,507	24
25	V	30 DEPRECIATION		STAYCARE MANAGEMENT, LTD.					25
26	V	32 INTEREST		STAYCARE MANAGEMENT, LTD.					26
27	V	34 BUILDING RENT		STAYCARE MANAGEMENT, LTD.		19,512		19,512	27
28	V	35 EQUIPMENT RENTAL		STAYCARE MANAGEMENT, LTD.		12,419		12,419	28
29	V								29
30	V								30
31	V	17 Management Fees	378,000					(378,000)	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 378,000			\$ 174,226	\$ *	(203,774)	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	1 DIET. COMP - S. WEBSTER	\$	STAY CARE MANAGEMENT, LTD.	100.00%	\$ 3,429	\$	3,429	15
16	V	1 DIET. COMP - D. WENGROW		STAY CARE MANAGEMENT, LTD.		3,429		3,429	16
17	V	6 MAINT. COMP. - NON-OWNER		STAY CARE MANAGEMENT, LTD.		6,969		6,969	17
18	V	7 EMP. BEN. - S. WEBSTER		STAY CARE MANAGEMENT, LTD.		309		309	18
19	V	7 EMP. BEN. - D. WENGROW		STAY CARE MANAGEMENT, LTD.		309		309	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER		STAY CARE MANAGEMENT, LTD.		783		783	20
21	V	17 ADMIN. COMP - H. WENGROW		STAY CARE MANAGEMENT, LTD.		15,000		15,000	21
22	V	17 ADMIN. COMP - J. WEBSTER		STAY CARE MANAGEMENT, LTD.		55,714		55,714	22
23	V	27 EMP. BEN. - H. WENGROW		STAY CARE MANAGEMENT, LTD.		1,010		1,010	23
24	V	27 EMP. BEN. - J. WEBSTER		STAY CARE MANAGEMENT, LTD.		3,754		3,754	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 90,706	\$ *	90,706	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	6 REPAIRS & MAINTENANCE	\$	DOUBLE YOU REALTY, LLC	100.00%	\$		15
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		390	390	16
17	V	21 OFFICE EXPENSE		DOUBLE YOU REALTY, LLC				17
18	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		472	472	18
19	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		3,830	3,830	19
20	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		6,094	6,094	20
21	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		7,231	7,231	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	19,512	DOUBLE YOU REALTY, LLC			(19,512)	26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 19,512			\$ 18,017	\$ * (1,495)	39

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

VII. RELATED PARTIES (continued)

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

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

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

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

Facility Name & ID Number

Atrium Health Care Center

0033977

Report Period Beginning:

01/01/09

Ending:

12/31/09

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	20.00	28.57%	Sal Staycare	\$ 55,714	17-7	1
2	Howard Wengrow	Owner	Administrative	30.94%	See Attached	5.00	7.69%	Sal Staycare	15,000	17-7	2
3	Yeruchom Levovitz	Owner	Administrative	1.25%	See Attached	25.00	41.67%	Salary	46,030	17-1	3
4	Sara Webster	Relative	Dietary	0%	See Attached	1.70	33.93%	Sal Staycare	3,429	01-07	4
5	David Wengrow	Relative	Asst Admin	1.25%	See Attached	25.00	100.00%	Salary	12,993	17-1	5
6	Debra Wengrow	Relative	Dietary	0%	See Attached	1.70	33.93%	Sal Staycare	3,429	01-07	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 136,595		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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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	209,325	6	\$ 6,940	\$ 55,344	\$ 1,835	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	209,325	6	8,208	55,344	2,170	2	
3	17	ADMIN. SAL.-NON OWNER	PATIENT DAYS	209,325	6	123,844	123,844	55,344	32,743	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	209,325	6	6,533	55,344	1,727	4	
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	209,325	6		55,344		5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	209,325	6	235,254	214,216	55,344	62,200	6
7	24	SEMINARS	PATIENT DAYS	209,325	6	1,433	55,344	379	7	
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	209,325	6	12,170	55,344	3,218	8	
9	26	INSURANCE	PATIENT DAYS	209,325	6	5,734	55,344	1,516	9	
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	209,325	6	138,077	55,344	36,507	10	
11	30	DEPRECIATION	PATIENT DAYS	209,325	6		55,344		11	
12	32	INTEREST	PATIENT DAYS	209,325	6	73,800	55,344		12	
13	34	BUILDING RENT	PATIENT DAYS	209,325	6	46,973	55,344	19,512	13	
14	35	EQUIPMENT RENTAL	PATIENT DAYS	209,325	6		55,344	12,419	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 658,966	\$ 338,060	\$ 174,226	25	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/09

Ending: 12/31/09

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	26,360	11	6,969	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	909	2	309	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	909	2	309	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,962	11	783	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	195,000	5	15,000	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	195,000	20	55,714	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	13,128	5	1,010	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	13,138	20	3,754	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					\$ 467,614	\$ 436,568	\$ 90,706	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	REPAIRS & MAINTENANCE	PATIENT DAYS	209,325	6	\$	\$ 55,344	\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	209,325	6	1,475	55,344	390	2
3	21	OFFICE EXPENSE	PATIENT DAYS	209,325	6	1	55,344		3
4	26	INSURANCE	PATIENT DAYS	209,325	6	1,785	55,344	472	4
5	30	DEPRECIATION	PATIENT DAYS	209,325	6	14,487	55,344	3,830	5
6	32	INTEREST EXPENSE	PATIENT DAYS	209,325	6	23,050	55,344	6,094	6
7	33	REAL ESTATE TAXES	PATIENT DAYS	209,325	6	27,349	55,344	7,231	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					\$ 68,147	\$	\$ 18,017	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

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Report Period Beginning:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

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: 01/01/09 Ending: 12/31/09

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:

01/01/09

Ending: 12/31/09

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
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

003977

Report Period Beginning:

01/01/09

Ending:

12/31/09

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1	2	3	4	5	6	7	8	9	10										
										Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
										YES	NO				Original	Balance			
A. Directly Facility Related																			
Long-Term																			
1	MB Financial		X	Mortgage			\$	\$ 6,489,918		\$ 220,611	1								
2	IDOR Interest Expense	X								5	2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	Due on Insurance		X	Prepaid Insurance				110,308		224	6								
7	Peterson Bank		X	Line of Credit						24,174	7								
8	See Supplemental Schedule									6,094	8								
9	TOTAL Facility Related						\$	\$ 6,600,226		\$ 251,109	9								
B. Non-Facility Related*																			
10	Interest Income		X							(21,328)	10								
11											11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (21,328)	14								
15	TOTALS (line 9+line14)						\$	\$ 6,600,226		\$ 229,781	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

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

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.)

Facility Name & ID Number

Atrium Health Care Center

0033977

Report Period Beginning:

01/01/09

Ending:

12/31/09

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		8	9	10									
						Name of Lender	Related**				Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
							YES							NO	Original				Balance
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term																		
	Working Capital																		
8	Allocated from Double You Realty	X					\$	\$			\$ 6,094	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital																		
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related																		

* 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.)

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/09

Ending:

12/31/09

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:

	1	2	3	4	
A. Land.	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>16,200</u>	<u>1990</u>	<u>\$ 74,000</u>	<u>1</u>
2	<u>Allocated from Double You</u>		<u>2003</u>	<u>13,220</u>	<u>2</u>
3	TOTALS	16,200		\$ 87,220	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1972	50,343		20				9
10	Various		1974	12,941		20				10
11	Various		1977	46,500		20				11
12	Various		1978	23,362		20				12
13	Various		1979	11,676		20			1,354	13
14	Various		1980	12,652		20			580	14
15	Various		1981	4,095		20			393	15
16	Various		1982	1,310		20			1,310	16
17	Various		1989	42,200		20	1,055	1,055	35,799	17
18	Various		1992	16,375		20	819	819	13,479	18
19	Various		1993	26,090		20	1,305	1,305	19,955	19
20	Various		1995	32,183		20	1,610	1,610	22,750	20
21	Various		1996	71,604		20	3,581	3,581	48,631	21
22	Various		1997	52,684		20	2,636	2,636	33,311	22
23	Various		1998	131,108		20	6,557	6,557	76,360	23
24	Various		1999	15,353		20	769	769	8,121	24
25	Various		2000	71,157		20	2,614	2,614	26,523	25
26	Various		2001	13,010		20	652	652	5,645	26
27	Various		2002	6,846		20	685	685	5,187	27
28	Various		2003	60,161		20	4,592	4,592	36,736	28
29	Various		2004	7,348		20	512	512	2,850	29
30	Various		2005	24,381		20	2,383	2,383	10,796	30
31										31
32										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 Depreciation-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		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12F & 12G)	919,825	114,375		26,504	(87,871)	786,886	67
68	Related Party Allocations (Pages 12H & 12I)	91,846	3,240		3,532	292	24,172	68
69	Financial Statement Depreciation		28,623			(28,623)		69
70	TOTAL (lines 4 thru 69)	\$ 1,745,050	\$ 146,238		\$ 59,806	\$ (86,432)	\$ 1,160,838	70

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:

01/01/09

Ending:

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XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,745,050	\$ 146,238		\$ 59,806	\$ (86,432)	\$ 1,160,838	1
2	Elevator Pump	2006	2,200		20	220	220	733	2
3	Elevator Recall System	2006	10,000		20	1,000	1,000	3,333	3
4	Stairway Railings	2006	4,320		20	432	432	1,332	4
5	Onan Generator	2006	9,654		20	965	965	3,781	5
6	Plumbing	2006	3,500		20	350	350	1,283	6
7	Cable	2006	6,320		20	1,360	1,360	4,193	7
8	Fire Alarm Repairs	2006	5,625		20	281	281	938	8
9	Wallpaper/Paint - Lobby/Dayroom	2007	6,765		20	338	338	987	9
10	Econocare, Inc. 31412 - Floors/Wallcovering/Window Treatments	2008	23,137		20	3,405	3,405	6,527	10
11	J. Franco Wrought Iron Fencing & Maintenance	2008	2,760		20	276	276	437	11
12	Advanced Generator	2008	2,579		20	129	129	193	12
13	Econocare, Inc. - Elevator Remodel: Walls/Floor/Ceiling/Light	2008	16,398		20	1,640	1,640	2,186	13
14	Long Elevator Ma10130349	2008	3,142		20	157	157	196	14
15	35 New Doors And Crown Molding	2009	34,435		20	2,870	2,870	2,870	15
16	Corner Guards, Wood Blinds, Curtains, Curtain Tracks, And Ren	2009	14,288		20	953	953	953	16
17	Aluminum Identification Signage/Exterior	2009	6,955		20	464	464	464	17
18	Wallcovering Field And Accent For Therapy Room	2009	6,676		20	213	213	213	18
19	Removal And Installation Of Wallcovering	2009	19,149		20	479	479	479	19
20	Installing Wallcovering And Wallpaper	2009	5,809		20	242	242	242	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)		\$ 1,928,762	\$ 146,238		\$ 75,580	\$ (70,658)	\$ 1,192,178	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:

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Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 1,928,762	\$ 146,238		\$ 75,580	\$ (70,658)	\$ 1,192,178	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)	\$ 1,928,762	\$ 146,238		\$ 75,580	\$ (70,658)	\$ 1,192,178	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

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Report Period Beginning:

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Ending:

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XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 1,928,762	\$ 146,238		\$ 75,580	\$ (70,658)	\$ 1,192,178	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)	\$ 1,928,762	\$ 146,238		\$ 75,580	\$ (70,658)	\$ 1,192,178	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:

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12/31/09

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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		\$ 1,928,762	\$ 146,238		\$ 75,580	\$ (70,658)	\$ 1,192,178	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)	\$ 1,928,762	\$ 146,238		\$ 75,580	\$ (70,658)	\$ 1,192,178	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

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XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3	Atrium Healthcare Center Limited Partner	1972	574,854	114,375	33	26,504	(87,871)	786,886	3
4		1972	344,971		20				4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information Continued		\$	\$		\$	\$	\$	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
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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 (12F & 12G lines 1 thru 33)		\$ 919,825	\$ 114,375		\$ 26,504	\$ (87,871)	\$ 786,886	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 Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You	2003	126,362	3,240	39	3,240		22,546	3
4	Allocated Costs 5% Over Facility Building& Improv 2003	2003	(40,369)						4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Staycare	2003	5,853		20	292	292	1,626	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 Depreciation-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)	\$ 91,846	\$ 3,240		\$ 3,532	\$ 292	\$ 24,172	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:

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XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 157,377	\$ 590	\$ 21,772	\$ 21,182	10	\$ 102,630	71
72	Current Year Purchases	13,194		1,325	1,325	10	1,325	72
73	Fully Depreciated Assets	397,927				10	397,927	73
74								74
75	TOTALS	\$ 568,498	\$ 590	\$ 23,097	\$ 22,507		\$ 501,882	75

D. Vehicle Depreciation (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	2009	\$ 7,402	\$	\$ 740	\$ 740	5	\$ 7,402	76
77										77
78										78
79										79
80	TOTALS			\$ 7,402	\$	\$ 740	\$ 740		\$ 7,402	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,591,882	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 146,828	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 99,417	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (47,411)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,701,462	85

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

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

If NO, see instructions. YES NO

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

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

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

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental?

YES NO

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

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Staycare		\$	\$ 12,419	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 12,419	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. _____/2009 \$ _____

13. _____/2010 \$ _____

14. _____/2011 \$ _____

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5	6	7	8		
			Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)						Total Cost (Col. 3 + 5 + 6)
			Units of Service	Cost	Units	Cost								
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$	173,735	\$			\$	173,735	1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				31,088					31,088	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	39 - 03	hrs				158,550					158,550	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						126,698			126,698	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Other (specify):												12	
13	Other (specify): See Supplemental												13	
14	TOTAL			\$		\$	363,373	\$	126,698	\$		490,071	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: 01/01/09

Ending: 12/31/09

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/09

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ 955,944	\$ 974,369	1
2	Cash-Patient Deposits	128	128	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,319,762	1,319,762	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	123,957	123,957	6
7	Other Prepaid Expenses	871	871	7
8	Accounts Receivable (owners or related parties)	32,507	32,507	8
9	Other(specify): <u>See Attached Schedule</u>		(32,507)	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,433,169	\$ 2,419,087	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		237,434	13
14	Buildings, at Historical Cost		4,460,623	14
15	Leasehold Improvements, at Historical Cost	574,292	574,292	15
16	Equipment, at Historical Cost	281,265	761,265	16
17	Accumulated Depreciation (book methods)	(465,829)	(2,818,720)	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	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 389,728	\$ 3,260,025	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,822,897	\$ 5,679,112	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 125,166	\$ 125,166	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	110,308	110,308	29
30	Accrued Salaries Payable	90,935	90,935	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	200,686	200,686	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,036	3,036	35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	13,923	13,923	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 544,054	\$ 544,054	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		6,489,918	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>See Attached Schedule</u>			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 6,489,918	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 544,054	\$ 7,033,972	46
47	TOTAL EQUITY(page 18, line 24)	\$ 2,278,843	\$ (1,354,860)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,822,897	\$ 5,679,112	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,776,404	1
2	Restatements (describe):		2
3	<u>Replacement Tax</u>	(7,217)	3
4	<u>Other Adjusting Journal Entries</u>	(666)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,768,521	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	510,322	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 510,322	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,278,843	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

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	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,017,763	1
2	Discounts and Allowances for all Levels	(869,993)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,147,770	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	754,902	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 754,902	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	234,290	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,143	19
20	Radiology and X-Ray		20
21	Other Medical Services	21,453	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 265,886	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	21,328	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,328	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	377,572	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 377,572	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,567,458	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,127,286	31
32	Health Care	1,956,778	32
33	General Administration	1,648,424	33
B. Capital Expense			
34	Ownership	2,746,977	34
C. Ancillary Expense			
35	Special Cost Centers	490,071	35
36	Provider Participation Fee	87,600	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,057,136	40
41	Income before Income Taxes (line 30 minus line 40)**	510,322	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 510,322	43

* 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:

01/01/09

Ending:

12/31/09

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	3,465	3,649	\$ 112,648	\$ 30.87	1
2	Assistant Director of Nursing	735	763	18,083	23.70	2
3	Registered Nurses	12,331	13,148	349,172	26.56	3
4	Licensed Practical Nurses	19,213	19,862	462,921	23.31	4
5	CNAs & Orderlies	48,625	51,600	510,217	9.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,896	1,950	21,128	10.83	8
9	Activity Director	1,780	1,982	22,112	11.16	9
10	Activity Assistants	4,674	5,028	46,165	9.18	10
11	Social Service Workers	5,335	5,763	81,507	14.14	11
12	Dietician					12
13	Food Service Supervisor	1,892	2,073	32,521	15.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,147	21,968	231,947	10.56	15
16	Dishwashers					16
17	Maintenance Workers	2,198	2,422	47,974	19.81	17
18	Housekeepers	19,768	21,589	230,756	10.69	18
19	Laundry	4,753	5,215	73,845	14.16	19
20	Administrator	2,377	2,499	110,803	44.34	20
21	Assistant Administrator	279	293	12,993	44.34	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,705	6,044	58,287	9.64	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	1,538	1,806	26,374	14.60	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,658	6,210	185,493	29.87	33
34	TOTAL (lines 1 - 33)	162,369	173,864	\$ 2,634,946 *	\$ 15.16	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	Monthly	\$ 9,445	01-03	35
36	Medical Director	Monthly	18,000	09-03	36
37	Medical Records Consultant	Monthly	4,320	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,400	10-03	39
40	Physical Therapy Consultant	6	254	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	85	10a-03	43
44	Activity Consultant	43	2,394	11-03	44
45	Social Service Consultant	29	1,611	12-03	45
46	Other(specify)				46
47	Religious Service	Monthly	3,550	01-03	47
48					48
49	TOTAL (lines 35 - 48)	80	\$ 42,059		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. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
<u>Yeruchom Levovitz (1/1/09 - 6/1/09)</u>	<u>Administrator</u>	<u>1.25</u>	<u>\$ 47,530</u>	<u>Workers' Compensation Insurance</u>	<u>\$ 98,384</u>	<u>IDPH License Fee</u>	<u>\$ 1,990</u>	
<u>Karen Guiterrez (5/18/09 - Present)</u>	<u>Administrator</u>		<u>63,273</u>	<u>Unemployment Compensation Insurance</u>	<u>14,029</u>	<u>Advertising: Employee Recruitment</u>	<u>3,088</u>	
<u>David Wengrow</u>	<u>Asst. Admin</u>	<u>1.25</u>	<u>12,993</u>	<u>FICA Taxes</u>	<u>198,935</u>	<u>Health Care Worker Background Check</u>		
				<u>Employee Health Insurance</u>	<u>107,767</u>	<u>(Indicate # of checks performed <u>110</u>)</u>	<u>1,100</u>	
				<u>Employee Meals</u>	<u>34,420</u>	<u>Patient Background Checks</u>		
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>		<u>ICLTC</u>	<u>13,440</u>	
				<u>Union Pension Expense</u>	<u>20,544</u>	<u>Dues</u>	<u>1,920</u>	
				<u>401K</u>	<u>2,166</u>	<u>Licenses & Fees</u>	<u>2,489</u>	
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 123,796	<u>Chicago Head Tax</u>	<u>4,600</u>	<u>Yellow Pages</u>	<u>6,904</u>	
(List each licensed administrator separately.)				<u>Employee Benefits</u>	<u>297</u>			
				<u>Christmas Expense</u>	<u>1,720</u>	<u>Less: Public Relations Expense</u>	<u>(5,456)</u>	
						<u>Non-allowable advertising</u>	<u>()</u>	
						<u>Yellow page advertising</u>	<u>(6,904)</u>	
						TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,570	
				TOTAL (agree to Schedule V, line 22, col.8)	\$ 482,861			
B. Administrative - Other								
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				
<u>Staycare Management - Management Fees</u>			<u>\$ 378,000</u>	Description	Line #	Amount	Description	Amount
							<u>Out-of-State Travel</u>	<u>\$</u>
							<u>In-State Travel</u>	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 378,000				<u>Seminar Expense</u>	<u>1,068</u>
(Attach a copy of any management service agreement)							<u>Allocated from Staycare</u>	<u>379</u>
							<u>Entertainment Expense</u>	<u>()</u>
							TOTAL (agree to Sch. V, line 24, col. 8)	\$ 1,447
C. Professional Services				TOTAL		\$		
Vendor/Payee	Type		Amount					
<u>See Attached</u>	<u>Legal Fees</u>		<u>\$ 6,824</u>					
<u>FR&R</u>	<u>Accounting</u>		<u>25,612</u>					
<u>Personnel Planners</u>	<u>Unemployment Consult.</u>		<u>1,338</u>					
<u>MDI Technologies</u>	<u>Computer</u>		<u>5,070</u>					
<u>KBC Computer Services</u>	<u>Computer</u>		<u>2,425</u>					
<u>Real Estate</u>	<u>Legal Fees</u>		<u>927</u>					
TOTAL (agree to Schedule V, line 19, column 3)			\$ 42,196					
(If total legal fees exceed \$5,000, attach copy of invoices.)								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

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								
					FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/09

Ending:

12/31/09

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 \$13,440 IAHC \$1,920
- (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. \$ 18,633 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 X NO 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. \$ 34,420 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? Yes
Attach invoices and a summary of services for all architect and appraisal fees.