

Facility Name & ID Number Atrium Health Care Center

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

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	58,560	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	58,560	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	Private Pay	4 Other			
8	SNF	29,484	118	3,147	32,749	8	
9	SNF/PED					9	
10	ICF	21,883	10	245	22,138	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	51,367	128	3,392	54,887	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.73%

D. How many bed-hold days during this year were paid by the Department? 762 (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 3,147

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: 12/31/2012 Fiscal Year: 12/31/2012

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

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	284,469	48,463	10,623	343,555		343,555	6,858	350,413		1
2	Food Purchase		251,056		251,056	(38,715)	212,341	(6)	212,335		2
3	Housekeeping	223,105	26,547		249,652		249,652		249,652		3
4	Laundry	79,654	11,315		90,969		90,969		90,969		4
5	Heat and Other Utilities			112,385	112,385		112,385	(3,101)	109,284		5
6	Maintenance	78,117	34,779	46,045	158,941		158,941	10,808	169,749		6
7	Other (specify):*							1,398	1,398		7
8	TOTAL General Services	665,345	372,160	169,053	1,206,558	(38,715)	1,167,843	15,957	1,183,800		8
	B. Health Care and Programs										
9	Medical Director			21,000	21,000		21,000		21,000		9
10	Nursing and Medical Records	1,778,136	68,397	14,220	1,860,753		1,860,753		1,860,753		10
10a	Therapy	22,877		651	23,528		23,528		23,528		10a
11	Activities	77,526	3,145	3,193	83,864		83,864		83,864		11
12	Social Services	122,468	41,722	6,460	170,650		170,650		170,650		12
13	CNA Training										13
14	Program Transportation			450	450		450		450		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,001,007	113,264	45,974	2,160,245		2,160,245		2,160,245		16
	C. General Administration										
17	Administrative	107,811		414,000	521,811		521,811	(308,199)	213,612		17
18	Directors Fees										18
19	Professional Services			61,817	61,817	(6,090)	55,727	3,540	59,267		19
20	Dues, Fees, Subscriptions & Promotions			24,085	24,085		24,085	(9,784)	14,301		20
21	Clerical & General Office Expenses	82,089	40,653	18,991	141,733		141,733	54,388	196,121		21
22	Employee Benefits & Payroll Taxes			454,547	454,547	38,715	493,262		493,262		22
23	Inservice Training & Education										23
24	Travel and Seminar			1,700	1,700		1,700	300	2,000		24
25	Other Admin. Staff Transportation			3,183	3,183		3,183	4,264	7,447		25
26	Insurance-Prop.Liab.Malpractice			117,984	117,984		117,984	2,195	120,179		26
27	Other (specify):*							43,633	43,633		27
28	TOTAL General Administration	189,900	40,653	1,096,307	1,326,860	32,625	1,359,485	(209,663)	1,149,822		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,856,252	526,077	1,311,334	4,693,663	(6,090)	4,687,573	(193,706)	4,493,867		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.

Facility Name & ID Number Atrium Health Care Center

#0033977

Report Period Beginning:

01/01/12

Ending:

12/31/12

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 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			107,223	107,223		107,223	5,023	112,246			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			40,453	40,453		40,453	188,736	229,189			32
33	Real Estate Taxes			207,998	207,998	6,090	214,088	5,872	219,960			33
34	Rent-Facility & Grounds			2,665,000	2,665,000		2,665,000	(2,665,000)				34
35	Rent-Equipment & Vehicles			351	351		351	12,586	12,937			35
36	Other (specify):*											36
37	TOTAL Ownership			3,021,025	3,021,025	6,090	3,027,115	(2,452,783)	574,332			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		93,497	230,303	323,800		323,800		323,800			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			639,011	639,011		639,011		639,011			42
43	Other (specify):*			1,191	1,191		1,191	(1,191)				43
44	TOTAL Special Cost Centers		93,497	870,505	964,002		964,002	(1,191)	962,811			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,856,252	619,574	5,202,864	8,678,690		8,678,690	(2,647,680)	6,031,010			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

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	(4,632)	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	(118,268)	30		9
10	Interest and Other Investment Income	(420)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(6)	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	(4,077)	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	(1,196)	20		28
29	Other-Attach Schedule	(63,990)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (192,589)		\$	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)	(2,455,091)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (2,455,091)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (2,647,680)		37

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

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

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

BHF USE ONLY							
48		49		50		51	52

SEE ACCOUNTANTS' COMPILATION REPORT

Atrium Health Care Center

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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Cope Dues	\$ (8,588)	20	1
2	Building Co. Accounting Fees	(975)	19	2
3	Building Co. Amortization	(4,513)	36	3
4	Building Co. Illinois Replacement Tax	(33,152)	21	4
5	Miscellaneous Income	(11,233)	21	5
6	Marketing Expense	(1,191)	43	6
7	Replacement Tax	(1,499)	21	7
8	Non Allowable Legal Fees	(2,557)	19	8
9	Non Allowable Consulting Fee	(282)	21	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	(63,990)		49

Atrium Health Care Center

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

ID# 0033977

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:

01/01/12

Ending:

12/31/12

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	(6)											(6)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(4,632)		1,531									(3,101)	5
6	Maintenance			2,409	6,247	2,152							10,808	6
7	Other (specify):*				1,398								1,398	7
8	TOTAL General Services	(4,638)		3,940	14,503	2,152							15,957	8
	B. Health Care and Programs													
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	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(380,727)	72,528								(308,199)	17
18	Directors Fees													18
19	Professional Services	(3,532)	975	5,782		315							3,540	19
20	Fees, Subscriptions & Promotions	(9,784)											(9,784)	20
21	Clerical & General Office Expenses	(50,243)	33,152	71,479									54,388	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			300									300	24
25	Other Admin. Staff Transportation			4,264									4,264	25
26	Insurance-Prop.Liab.Malpractice			1,822		373							2,195	26
27	Other (specify):*			39,350	4,283								43,633	27
28	TOTAL General Administration	(63,559)	34,127	(257,730)	76,811	688							(209,663)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(68,197)	34,127	(253,790)	91,314	2,840							(193,706)	29

STATE OF ILLINOIS

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/12

Ending:

Summary B

12/31/12

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	(118,268)	114,375	6,018		2,898							5,023	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(420)	185,779	20		3,357							188,736	32
33	Real Estate Taxes					5,872							5,872	33
34	Rent-Facility & Grounds		(2,665,000)	17,456		(17,456)							(2,665,000)	34
35	Rent-Equipment & Vehicles			12,586									12,586	35
36	Other (specify):*	(4,513)	4,513											36
37	TOTAL Ownership	(123,201)	(2,360,333)	36,080		(5,329)							(2,452,783)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(1,191)											(1,191)	43
44	TOTAL Special Cost Centers	(1,191)											(1,191)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(192,589)	(2,326,206)	(217,710)	91,314	(2,489)							(2,647,680)	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See 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	\$ 2,665,000	Atrium Healthcare Center Ltd. Partnership		\$	\$ (2,665,000)	1
2	V	32 Interest Income	5,019	Atrium Healthcare Center Ltd. Partnership			(5,019)	2
3	V	19 Accounting Fees		Atrium Healthcare Center Ltd. Partnership		975	975	3
4	V	32 Mortgage Interest		Atrium Healthcare Center Ltd. Partnership		190,798	190,798	4
5	V	30 Depreciation		Atrium Healthcare Center Ltd. Partnership		114,375	114,375	5
6	V	36 Amortization		Atrium Healthcare Center Ltd. Partnership		4,513	4,513	6
7	V	21 Illinois RT		Atrium Healthcare Center Ltd. Partnership		33,152	33,152	7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 2,670,019			\$ 343,813	\$ * (2,326,206)	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%	\$ 1,531	\$ 1,531
16	V	6 REPAIRS AND MAINT.				2,409	2,409
17	V	17 ADMIN. SALARY				33,273	33,273
18	V	19 PROFESSIONAL FEES				5,782	5,782
19	V	21 CLERICAL & GENERAL				71,479	71,479
20	V	24 SEMINARS				300	300
21	V	25 ADMIN. STAFF TRAVEL				4,264	4,264
22	V	26 INSURANCE				1,822	1,822
23	V	27 EMPLOYEE BENEFITS				39,350	39,350
24	V	30 DEPRECIATION				6,018	6,018
25	V	32 INTEREST				20	20
26	V	34 BUILDING RENT				17,456	17,456
27	V	35 EQUIPMENT RENTAL				12,586	12,586
28	V						
29	V						
30	V						
31	V						
32	V	17 MANAGEMENT FEES	414,000	STAYCARE MANAGEMENT, LTD.			(414,000)
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 414,000			\$ 196,290	\$ * (217,710)

* 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				6,247		6,247	17
18	V	7 EMP. BEN. - S. WEBSTER				348		348	18
19	V	7 EMP. BEN. - D. WENGROW				348		348	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER				702		702	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	27 EMP. BEN. - H. WENGROW				904		904	23
24	V	27 EMP. BEN. - J. WEBSTER				3,379		3,379	24
25	V	27 EMP. BEN. - DAVID WENGROW							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		\$			\$ 91,314	\$ *	91,314	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 AND MAINTENANCE	\$	DOUBLE YOU REALTY, LLC	100.00%	\$ 2,152	\$ 2,152
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		315	315
17	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		373	373
18	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		2,898	2,898
19	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		3,357	3,357
20	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		5,872	5,872
21	V						
22	V						
23	V						
24	V						
25	V						
26	V	34 RENT	17,456	DOUBLE YOU REALTY, LLC			(17,456)
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 17,456			\$ 14,967	\$ * (2,489)

* 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: 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: 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

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, BOOKK	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

Facility Name & ID Number

Atrium Health Care Center

0033977

Report Period Beginning:

01/01/12

Ending:

12/31/12

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

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jeffrey Webster	Owner	Administrative	26.69%	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	1.42	23.67%	Alloc. Salary	2,838	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	\$ 82,224		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:

01/01/12

Ending: 12/31/12

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:

01/01/12

Ending: 12/31/12

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	232,046	6	\$ 6,471	\$ 54,887	\$ 1,531	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	232,046	6	10,187	54,887	2,409	2
3	17	ADMIN. SALARY	PATIENT DAYS	232,046	6	140,668	140,668	54,887	33,273
4	19	PROFESSIONAL FEES	PATIENT DAYS	232,046	6	24,445	54,887	5,782	4
5	21	CLERICAL & GENERAL	PATIENT DAYS	232,046	6	302,190	252,516	54,887	71,479
6	24	SEMINARS	PATIENT DAYS	232,046	6	1,268	54,887	300	6
7	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	232,046	6	18,029	54,887	4,264	7
8	26	INSURANCE	PATIENT DAYS	232,046	6	7,704	54,887	1,822	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	232,046	6	166,361	54,887	39,350	9
10	30	DEPRECIATION	PATIENT DAYS	232,046	6	25,442	54,887	6,018	10
11	32	INTEREST	PATIENT DAYS	232,046	6	84	54,887	20	11
12	34	BUILDING RENT	PATIENT DAYS	232,046	6	73,800	54,887	17,456	12
13	35	EQUIPMENT RENTAL	PATIENT DAYS	232,046	6	53,208	54,887	12,586	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					\$ 829,857	\$ 393,184	\$ 196,290	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/12

Ending: 12/31/12

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	9	6,247	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,026	2	348	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	1,026	2	348	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	2,969	9	702	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	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	11,758	5	904	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	11,827	20	3,379	10
11	27	EMP. BEN. - DAVID WENGROV	AVG. HOURS WORKED	40	1	567		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					\$ 475,791	\$ 446,618	\$ 91,314	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/12

Ending: 12/31/12

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	6	REPAIRS AND MAINTENANCE	PATIENT DAYS	232,046	6	\$ 9,100	\$ 54,887	\$ 2,152	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	232,046	6	1,330	54,887	315	2
3	26	INSURANCE	PATIENT DAYS	232,046	6	1,579	54,887	373	3
4	30	DEPRECIATION	PATIENT DAYS	232,046	6	12,254	54,887	2,898	4
5	32	INTEREST EXPENSE	PATIENT DAYS	232,046	6	14,192	54,887	3,357	5
6	33	REAL ESTATE TAXES	PATIENT DAYS	232,046	6	24,823	54,887	5,872	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 63,278	\$	\$ 14,967	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/12

Ending: 12/31/12

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:

01/01/12

Ending: 12/31/12

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:

01/01/12

Ending: 12/31/12

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:

01/01/12

Ending: 12/31/12

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

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:

01/01/12

Ending: 12/31/12

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:

01/01/12

Ending:

12/31/12

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			\$	\$ 5,609,150		\$ 190,798	1								
2											2								
3											3								
4											4								
5	See Supplemental Schedule										5								
Working Capital																			
6	MB Financial		X	Line of Credit						40,453	6								
7	Allocated from Staycare		X							20	7								
8	See Supplemental Schedule									3,357	8								
9	TOTAL Facility Related						\$	\$ 5,609,150		\$ 234,628	9								
B. Non-Facility Related*																			
10	Interest Income		X							(420)	10								
11	Interest Income (Building Co.)		X							(5,019)	11								
12											12								
13	See Supplemental Schedule										13								
14	TOTAL Non-Facility Related						\$	\$		\$ (5,439)	14								
15	TOTALS (line 9+line14)						\$	\$ 5,609,150		\$ 229,189	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

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

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:

01/01/12

Ending:

12/31/12

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			
A. Directly Facility Related																				
Long-Term																				
1										1										
2										2										
3										3										
4										4										
5										5										
6										6										
7	TOTAL Long-Term										7									
Working Capital																				
8	Allocated from Double You		X				\$	\$		\$ 3,357	8									
9											9									
10											10									
11											11									
12											12									
13											13									
14	TOTAL Working Capital										14									
B. Non-Facility Related*																				
15							\$	\$		\$	15									
16											16									
17											17									
18											18									
19											19									
20	TOTAL Non-Facility Related										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 2011 report.	\$	221,018	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.)	\$	215,148	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(5,870)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	219,740	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$	6,090	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ <u>2,685</u> For <u>2008</u> Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	219,960	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2007	168,384	8
	2008	170,073	9
	2009	201,383	10
	2010	210,150	11
	2011	209,276	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2011	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

2012 Accrual = \$209,276 x 1.05 = \$219,739.80

Allocated from Double You - \$5,872

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.

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

2011 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 2011 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 2011.

	(A) <u>Tax Index Number</u>	(B) <u>Property Description</u>	(C) <u>Total Tax</u>	(D) <u>Tax Applicable to Nursing Home</u>
1.	<u>11-32-105-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>2,948.75</u>	\$ <u>2,948.75</u>
2.	<u>11-32-105-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>52,644.62</u>	\$ <u>52,644.62</u>
3.	<u>11-32-105-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>101,328.32</u>	\$ <u>101,328.32</u>
4.	<u>11-32-105-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>52,354.69</u>	\$ <u>52,354.69</u>
5.	<u>10-35-329-014-0000</u>	<u>Home Office</u>	\$ <u>25,108.36</u>	\$ <u>5,939.01</u>
6.	_____	\$ _____	_____	\$ _____
7.	_____	\$ _____	_____	\$ _____
8.	_____	\$ _____	_____	\$ _____
9.	_____	\$ _____	_____	\$ _____
10.	_____	\$ _____	_____	\$ _____
TOTALS			\$ <u>234,384.74</u>	\$ <u>215,215.39</u>

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? X YES _____ NO

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

C. Tax Bills

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/12

Ending:

12/31/12

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>26,895</u>	<u>1975</u>	<u>\$ 124,712</u>	<u>1</u>
2	<u>Allocated from Double You</u>			<u>11,827</u>	<u>2</u>
3	TOTALS	26,895		\$ 136,539	3

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)	\$ 866,398	4
5			1972	344,971		20				5
6										6
7										7
8										8
Improvement Type**										
9	Various		1972	50,343		20				9
10	Various		1974	12,941		20				10
11	Various		1977	46,500		20				11
12	Various		1978	23,362		20				12
13	Various		1979	11,676		20			1,354	13
14	Various		1980	12,652		20			580	14
15	Various		1981	4,095		20			393	15
16	Various		1982	1,310		20			1,310	16
17	Various		1989	42,200		20			35,799	17
18	Various		1992	16,375		20	68	68	15,185	18
19	Various		1993	26,090		20	1,305	1,305	23,870	19
20	Various		1995	32,183		20	1,609	1,609	27,577	20
21	Various		1996	71,604		20	3,580	3,580	59,372	21
22	Various		1997	52,684		20	2,634	2,634	41,213	22
23	Various		1998	131,108		20	6,555	6,555	96,026	23
24	Various		1999	15,353		20	768	768	10,424	24
25	Various		2000	71,157		20	2,616	2,616	34,368	25
26	Various		2001	13,010		20	651	651	7,598	26
27	Various		2002	6,846		20	290	290	6,846	27
28	Various		2003	60,162		20	3,663	3,663	48,111	28
29	Various		2004	7,347		20	511	511	4,384	29
30	Various		2005	24,381		20	2,016	2,016	15,858	30
31	Various		2006	41,619		20	3,881	3,881	24,991	31
32	Various		2007	6,765		20	338	338	2,001	32
33	Various		2008	48,015		20	5,507	5,507	25,870	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		\$	\$		\$	\$	\$	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								67
68		118,285	2,898		3,161	263	31,369	68
69			107,223			(107,223)		69
70		\$ 1,867,888	\$ 224,496		\$ 65,657	\$ (158,839)	\$ 1,380,896	70

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	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		\$ 1,867,888	\$ 224,496		\$ 65,657	\$ (158,839)	\$ 1,380,896	1
2	35 New Doors And Crown Molding	2009	34,435		20	3,444	3,444	13,200	2
3	Corner Guards, Wood Blinds, Curtains, Curtain Tracks, And Ren	2009	14,288		20	1,429	1,429	5,239	3
4	Aluminum Identification Signage/Exterior	2009	6,955		20	695	695	2,550	4
5	Wallcovering Field And Accent For Therapy Room	2009	6,676		20	668	668	2,559	5
6	Removal And Installation Of Wallcovering	2009	19,149		20	1,915	1,915	6,224	6
7	Installing Wallcovering And Wallpaper	2009	5,809		20	581	581	1,985	7
8	Pegasus Remodeling - Flooring, Baseboard, Paint, Wallpaper, Cab	2010	12,755		20	1,276	1,276	3,082	8
9	Pegasus Remodeling - Crown Molding, Doors	2010	31,695		20	3,170	3,170	7,660	9
10	Static Fire Dampers	2010	2,788		20	279	279	604	10
11	Fire Sprinkler Work	2010	2,950		20	148	148	381	11
12	Motor / Blower Units	2010	2,758		20	138	138	414	12
13	Fire Sprinkler	2011	6,438		20	644	644	1,073	13
14	Water Heater	2011	13,172		20	1,317	1,317	2,086	14
15	Kitchen Walk-In Cooler	2011	2,995		20	599	599	699	15
16	Walk-In Cooler	2011	2,561		20	512	512	726	16
17	Wall Covering	2012	10,115		20	1,012	1,012	1,180	17
18	Vinyl Tile In 3Rd Floor Corridor	2012	20,209		20	2,021	2,021	2,021	18
19	Remove And Install Flooring	2012	34,979		20	4,081	4,081	4,081	19
20	Vinyl Tile In 2Nd Floor Corridor	2012	20,209		20	1,684	1,684	1,684	20
21	Wallcovering Light Fixtures, Painting, Molding, Etc	2012	63,206		20	5,300	5,300	5,300	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)		\$ 2,182,030	\$ 224,496		\$ 96,567	\$ (127,929)	\$ 1,443,642	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		\$ 2,182,030	\$ 224,496		\$ 96,567	\$ (127,929)	\$ 1,443,642	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)	\$ 2,182,030	\$ 224,496		\$ 96,567	\$ (127,929)	\$ 1,443,642	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		\$ 2,182,030	\$ 224,496		\$ 96,567	\$ (127,929)	\$ 1,443,642	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)	\$ 2,182,030	\$ 224,496		\$ 96,567	\$ (127,929)	\$ 1,443,642	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		\$ 2,182,030	\$ 224,496		\$ 96,567	\$ (127,929)	\$ 1,443,642	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)	\$ 2,182,030	\$ 224,496		\$ 96,567	\$ (127,929)	\$ 1,443,642	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	Building Company Information								1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									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 (12F & 12G lines 1 thru 33)		\$	\$		\$	\$	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	Related Party Information		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You	2003	113,048	2,898	39	2,899	1	28,866	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Stavcare	2003	5,237		20	262	262	2,503	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.

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/12

Ending:

12/31/12

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)		\$ 118,285	\$ 2,898		\$ 3,161	\$ 263	\$ 31,369	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:

01/01/12

Ending:

12/31/12

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	\$ 155,483	\$	\$ 14,828	\$ 14,828	10	\$ 123,274	71
72	Current Year Purchases	7,754		636	636	10	636	72
73	Fully Depreciated Assets	437,872				10	437,872	73
74								74
75	TOTALS	\$ 601,109	\$	\$ 15,464	\$ 15,464		\$ 561,782	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	2012	\$ 8,005	\$ 6,018	\$ 215	\$ (5,803)	5	\$ 215	76
77										77
78										78
79										79
80	TOTALS			\$ 8,005	\$ 6,018	\$ 215	\$ (5,803)		\$ 215	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)	\$ 2,927,683	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 230,514	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 112,246	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (118,268)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,005,639	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: \$ 351 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>12,586</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>12,586</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. _____ /2013 \$ _____

13. _____ /2014 \$ _____

14. _____ /2015 \$ _____

* 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	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		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	\$		\$	107,707	\$		\$	107,707	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs				24,747				24,747	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	39 - 03	hrs				97,419				97,419	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39 - 02	# of prescripts					93,497			93,497	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>						430				430	13
14	TOTAL			\$		\$	230,303	\$	93,497	\$	323,800	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# 0033977Report Period Beginning: 01/01/12Ending: 12/31/12

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/12

(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	\$ 502,554	\$ 508,750	1
2	Cash-Patient Deposits	129	129	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,546,214	1,546,214	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	156,483	156,483	6
7	Other Prepaid Expenses	2,966	2,966	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Attached Schedule</u>			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,208,346	\$ 2,214,542	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		214,869	13
14	Buildings, at Historical Cost		4,460,623	14
15	Leasehold Improvements, at Historical Cost	797,078	797,078	15
16	Equipment, at Historical Cost	311,311	791,311	16
17	Accumulated Depreciation (book methods)	(631,877)	(3,327,893)	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>	1,339,109	45,131	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,815,621	\$ 2,981,119	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,023,967	\$ 5,195,661	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 216,777	\$ 216,776	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	170,347	170,347	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,375	2,375	31
32	Accrued Real Estate Taxes(Sch.IX-B)	219,740	219,740	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>See Attached Schedule</u>	243,508	243,508	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 852,747	\$ 852,746	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,609,150	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)	\$	\$ 5,609,150	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 852,747	\$ 6,461,896	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,171,220	\$ (1,266,235)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,023,967	\$ 5,195,661	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,933,877	1
2	Restatements (describe):		2
3	Rounding	(1)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,933,876	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	412,344	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	(175,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 237,344	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)	\$ 3,171,220	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	
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,047,721	1
2	Discounts and Allowances for all Levels	(621,338)	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,426,383	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	519,662	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 519,662	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	119,329	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,913	19
20	Radiology and X-Ray		20
21	Other Medical Services	7,409	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 130,651	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	420	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 420	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	13,918	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 13,918	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,091,034	30

		2	
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,206,558	31
2	HealthCare	2,160,245	32
33	General Administration	1,326,860	33
B. Capital Expense			
34	Ownership	3,021,025	34
C. Ancillary Expense			
35	Special Cost Centers	324,991	35
36	Provider Participation Fee	639,011	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,678,690	40
41	Income before Income Taxes (line 30 minus line 40)**	412,344	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 412,344	43

III. Net Inpatient Revenue detailed by Payer Source			
44	Medicaid - Net Inpatient Revenue	\$ 7,461,540	44
45	Private Pay - Net Inpatient Revenue	19,200	45
46	Medicare - Net Inpatient Revenue	911,340	46
47	Other-(specify) <u>Veterans</u>	34,303	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,426,383	49

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

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

0033977

Report Period Beginning:

01/01/12

Ending:

12/31/12

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	2,088	2,088	\$ 101,115	\$ 48.43	1
2	Assistant Director of Nursing	2,088	2,088	60,794	29.12	2
3	Registered Nurses	12,262	13,280	373,062	28.09	3
4	Licensed Practical Nurses	19,434	20,729	491,952	23.73	4
5	CNAs & Orderlies	48,739	52,509	513,519	9.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,914	2,074	22,877	11.03	8
9	Activity Director	1,675	1,971	23,167	11.75	9
10	Activity Assistants	5,232	5,581	54,359	9.74	10
11	Social Service Workers	7,966	8,566	122,468	14.30	11
12	Dietician					12
13	Food Service Supervisor	2,032	2,311	39,024	16.89	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,585	22,693	245,445	10.82	15
16	Dishwashers					16
17	Maintenance Workers	7,569	8,053	78,117	9.70	17
18	Housekeepers	21,358	23,001	223,105	9.70	18
19	Laundry	5,997	6,632	79,654	12.01	19
20	Administrator	1,928	2,080	107,811	51.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,430	8,221	82,089	9.99	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	1,853	2,101	31,889	15.18	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,739	6,315	205,805	32.59	33
34	TOTAL (lines 1 - 33)	175,889	190,293	\$ 2,856,252 *	\$ 15.01	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	\$ 10,623	01-03	35
36	Medical Director	Monthly	21,000	09-03	36
37	Medical Records Consultant	Monthly	4,512	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	9,533	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	16	651	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	57	3,193	11-03	44
45	Social Service Consultant	53	2,910	12-03	45
46	Other(specify)				46
47	<u>Religious Services</u>	Monthly	3,550	01-03	47
48	<u>Respiratory Care</u>	4	175	10-03	48
49	TOTAL (lines 35 - 48)	130	\$ 56,147		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								
													Amount of Expense Amortized Per Year							
													Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2007	FY2008	FY2009	FY2010
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:

01/01/12

Ending:

12/31/12**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. ILCLTC - \$16,320
- (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. \$ 23,616 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. \$ 639,011
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. \$ 38,715 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 100% line 14
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.

SEE ACCOUNTANTS' COMPILATION REPORT