

Facility Name & ID Number Atrium Health Care Center

0033977 Report Period Beginning: 01/01/15 Ending: 12/31/15

III. STATISTICAL DATA

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

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

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				5	
		3 Medicaid Recipient	Private Pay	4 Other	Total		
8	SNF	21,058	307	2,007	23,372	8	
9	SNF/PED					9	
10	ICF	29,489	116	89	29,694	10	
11	ICF/DD					11	
12	SC					12	
13	DD 16 OR LESS					13	
14	TOTALS	50,547	423	2,096	53,066	14	

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.87%

D. How many bed-hold days during this year were paid by the Department? None (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 116 and days of care provided 1,966

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: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	245,567	60,353	11,146	317,066		317,066	13,609	330,675		1
2	Food Purchase		259,413		259,413	(41,004)	218,409	(21)	218,388		2
3	Housekeeping	192,282	36,450		228,732		228,732		228,732		3
4	Laundry	68,791	10,164		78,955		78,955		78,955		4
5	Heat and Other Utilities			150,232	150,232		150,232	(3,178)	147,054		5
6	Maintenance	95,734	25,292	51,889	172,915		172,915	5,827	178,742		6
7	Other (specify):*							2,312	2,312		7
8	TOTAL General Services	602,374	391,672	213,267	1,207,313	(41,004)	1,166,309	18,549	1,184,858		8
	B. Health Care and Programs										
9	Medical Director			24,000	24,000		24,000		24,000		9
10	Nursing and Medical Records	1,724,408	61,688	28,798	1,814,894		1,814,894	(2,640)	1,812,254		10
10a	Therapy	24,548		1,575	26,123		26,123		26,123		10a
11	Activities	80,508	1,176	531	82,215		82,215		82,215		11
12	Social Services	135,679		5,852	141,531		141,531		141,531		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,965,143	62,864	60,756	2,088,763		2,088,763	(2,640)	2,086,123		16
	C. General Administration										
17	Administrative	102,555		465,850	568,405		568,405	(360,680)	207,725		17
18	Directors Fees										18
19	Professional Services			181,932	181,932	(2,970)	178,962	(71,559)	107,403		19
20	Dues, Fees, Subscriptions & Promotions			45,276	45,276		45,276	(7,055)	38,221		20
21	Clerical & General Office Expenses	82,073	31,060	58,778	171,911		171,911	30,542	202,453		21
22	Employee Benefits & Payroll Taxes			452,549	452,549	41,004	493,553		493,553		22
23	Inservice Training & Education										23
24	Travel and Seminar			424	424		424	224	648		24
25	Other Admin. Staff Transportation			1,724	1,724		1,724	5,233	6,957		25
26	Insurance-Prop.Liab.Malpractice			153,635	153,635		153,635	2,974	156,609		26
27	Other (specify):*							64,021	64,021		27
28	TOTAL General Administration	184,628	31,060	1,360,168	1,575,856	38,034	1,613,890	(336,299)	1,277,591		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,752,145	485,596	1,634,191	4,871,932	(2,970)	4,868,962	(320,389)	4,548,573		29

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

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

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			13,858	13,858		13,858	114,853	128,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,224	3,224		3,224	158,804	162,028			32
33	Real Estate Taxes			199,264	199,264	2,970	202,234	5,965	208,199			33
34	Rent-Facility & Grounds			2,300,000	2,300,000		2,300,000	(2,300,000)				34
35	Rent-Equipment & Vehicles							8,601	8,601			35
36	Other (specify):*											36
37	TOTAL Ownership			2,516,346	2,516,346	2,970	2,519,316	(2,011,777)	507,539			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		44,011	255,859	299,870		299,870		299,870			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			397,795	397,795		397,795		397,795			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		44,011	653,654	697,665		697,665		697,665			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,752,145	529,607	4,804,191	8,085,943		8,085,943	(2,332,167)	5,753,776			45

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

Atrium Health Care Center

ID# 0033977

Report Period Beginning: 01/01/15

Ending: 12/31/15

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Misc. Income	\$ (4,800)	21	1
2	Pharmacy - V.A.	(2,640)	10	2
3	MCA Sequester Reduction	(17,984)	21	3
4	Replacement Income Tax	(8,450)	21	4
5	Building Co. - Accounting Fees	(1,250)	19	5
6	Building Co. - Illinois RT	(20,786)	21	6
7	Collections Expense	(3,902)	21	7
8	Annual Report	(250)	20	8
9	PAC Dues	(5,702)	20	9
10	Non-Allowable Legal Fees	(80,994)	19	10
11	Capitalized R&M	(2,516)	06	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	(149,274)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/15

Ending:

12/31/15

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				13,609								13,609	1
2	Food Purchase	(21)											(21)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(5,197)		2,019									(3,178)	5
6	Maintenance	(2,516)		2,058	6,285								5,827	6
7	Other (specify):*				2,312								2,312	7
8	TOTAL General Services	(7,734)		4,077	22,206								18,549	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,640)											(2,640)	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	(2,640)											(2,640)	16
	C. General Administration													
17	Administrative			(429,653)	68,973								(360,680)	17
18	Directors Fees													18
19	Professional Services	(82,244)	1,250	9,068		367							(71,559)	19
20	Fees, Subscriptions & Promotions	(7,108)		53									(7,055)	20
21	Clerical & General Office Expenses	(76,030)	20,786	85,786									30,542	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			224									224	24
25	Other Admin. Staff Transportation			5,233									5,233	25
26	Insurance-Prop.Liab.Malpractice			2,419		555							2,974	26
27	Other (specify):*			59,523	4,498								64,021	27
28	TOTAL General Administration	(165,382)	22,036	(267,347)	73,471	923							(336,299)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(175,755)	22,036	(263,270)	95,677	923							(320,389)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15 Ending:

12/31/15

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(50,806)	162,204	549		2,905							114,853	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(2,281)	158,789			2,296							158,804	32
33	Real Estate Taxes					5,965							5,965	33
34	Rent-Facility & Grounds		(2,300,000)	17,497		(17,497)							(2,300,000)	34
35	Rent-Equipment & Vehicles			8,601									8,601	35
36	Other (specify):*													36
37	TOTAL Ownership	(53,087)	(1,979,007)	26,647		(6,330)							(2,011,777)	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
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(228,842)	(1,956,971)	(236,623)	95,677	(5,408)							(2,332,167)	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		

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	\$ 2,300,000	Atrium Healthcare Center Ltd. Partnership	100.00%	\$	\$ (2,300,000)	1
2	V	19 Accounting Fees		Atrium Healthcare Center Ltd. Partnership	100.00%	1,250	1,250	2
3	V	32 Mortgage Interest		Atrium Healthcare Center Ltd. Partnership	100.00%	158,789	158,789	3
4	V	30 Depreciation		Atrium Healthcare Center Ltd. Partnership	100.00%	162,204	162,204	4
5	V	21 Illinois RT		Atrium Healthcare Center Ltd. Partnership	100.00%	20,786	20,786	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		\$ 2,300,000			\$ 343,029	\$ * (1,956,971)	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%	\$ 2,019	\$ 2,019
16	V	6 REPAIRS AND MAINT.				2,058	2,058
17	V	17 ADMIN. SALARY				36,197	36,197
18	V	19 PROFESSIONAL FEES				9,068	9,068
19	V	20 DUES, SUBSCRIPTIONS				53	53
20	V	21 CLERICAL & GENERAL				85,786	85,786
21	V	24 SEMINARS				224	224
22	V	25 ADMIN. STAFF TRAVEL				5,233	5,233
23	V	26 INSURANCE				2,419	2,419
24	V	27 EMPLOYEE BENEFITS				59,523	59,523
25	V	30 DEPRECIATION				549	549
26	V	32 INTEREST EXPENSE					
27	V	34 BUILDING RENT				17,497	17,497
28	V	35 EQUIPMENT RENTAL				8,601	8,601
29	V						
30	V	17 MANAGEMENT FEES	465,850	STAYCARE MANAGEMENT, LTD.			(465,850)
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 465,850			\$ 229,227	\$ * (236,623)

* 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				10,180		10,180	16
17	V	6 MAINT. COMP.				6,285		6,285	17
18	V	7 EMP. BEN. - S. WEBSTER				469		469	18
19	V	7 EMP. BEN. - D. WENGROW				1,054		1,054	19
20	V	7 EMP. BEN. - MAINT. NON-OWNER				789		789	20
21	V	17 ADMIN. COMP - H. WENGROW				13,358		13,358	21
22	V	17 ADMIN. COMP - J. WEBSTER				55,615		55,615	22
23	V	27 EMP. BEN. - H. WENGROW				932		932	23
24	V	27 EMP. BEN. - J. WEBSTER				3,566		3,566	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		\$			\$ 95,677	\$ *	95,677	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		\$		100.00%	\$		15
16	V	19 PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC		367	367	16
17	V	26 INSURANCE		DOUBLE YOU REALTY, LLC		555	555	17
18	V	30 DEPRECIATION		DOUBLE YOU REALTY, LLC		2,905	2,905	18
19	V	32 INTEREST EXPENSE		DOUBLE YOU REALTY, LLC		2,296	2,296	19
20	V	19 RE TAX PROFESSIONAL FEES		DOUBLE YOU REALTY, LLC				20
21	V	33 REAL ESTATE TAXES		DOUBLE YOU REALTY, LLC		5,965	5,965	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V	34 RENT	17,497	DOUBLE YOU REALTY, LLC			(17,497)	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		\$ 17,497			\$ 12,089	\$ * (5,408)	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: 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: 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.

Facility Name & ID Number

Atrium Health Care Center

#

0033977

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	29.69%	See Attached	20.00	28.57%	Alloc. Salary	\$ 55,615	17-07	1	
2	Howard Wengrow	Owner	Administrative	30.9370%	See Attached	5.00	7.69%	Alloc. Salary	13,358	17-07	2	
3	Sara Webster	Relative	Dietary	0%	See Attached	1.70	33.93%	Alloc. Salary	3,429	01-07	3	
4	Deborah Wengrow	Relative	Dietary	0%	See Attached	1.70	33.93%	Alloc. Salary	10,180	01-07	4	
5	Ephraim Braunstein	Relative	Clerical	0%	See Attached	9.48	23.70%	Alloc. Salary	15,355	21-07	5	
6											6	
7											7	
8											8	
9											9	
10											10	
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts											11
12	anticipated to be considered allowable by the IL. Dept. of HFS.											12
13								TOTAL	\$ 97,937		13	

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	223,823	6	\$ 8,516	\$ 53,066	\$ 2,019	1	
2	6	REPAIRS AND MAINT.	PATIENT DAYS	223,823	6	8,680	53,066	2,058	2	
3	17	ADMIN. SALARY	PATIENT DAYS	223,823	6	152,674	152,674	53,066	36,197	3
4	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	38,246	53,066	9,068	4	
5	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	223,823	6	222	53,066	53	5	
6	21	CLERICAL & GENERAL	PATIENT DAYS	223,823	6	361,830	307,546	53,066	85,786	6
7	24	SEMINARS	PATIENT DAYS	223,823	6	945	53,066	224	7	
8	25	ADMIN. STAFF TRAVEL	PATIENT DAYS	223,823	6	22,074	53,066	5,233	8	
9	26	INSURANCE	PATIENT DAYS	223,823	6	10,203	53,066	2,419	9	
10	27	EMPLOYEE BENEFITS	PATIENT DAYS	223,823	6	251,057	53,066	59,523	10	
11	30	DEPRECIATION	PATIENT DAYS	223,823	6	2,315	53,066	549	11	
12	32	INTEREST	PATIENT DAYS	223,823	6		53,066		12	
13	34	BUILDING RENT	PATIENT DAYS	223,823	6	73,800	53,066	17,497	13	
14	35	EQUIPMENT RENTAL	PATIENT DAYS	223,823	6	36,278	53,066	8,601	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 966,840	\$ 460,220	\$ 229,227	25	

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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	10,104	2	3,429	1
2	1	DIET. COMP - D. WENGROW	AVG. HOURS WORKED	5	4	30,000	30,000	2	10,180	2
3	6	MAINT. COMP.	AVG. HOURS WORKED	40	6	26,510	26,510	9	6,285	3
4	7	EMP. BEN. - S. WEBSTER	AVG. HOURS WORKED	5	4	1,381		2	469	4
5	7	EMP. BEN. - D. WENGROW	AVG. HOURS WORKED	5	4	3,107		2	1,054	5
6	7	EMP. BEN. - MAINT. NON-OWN	AVG. HOURS WORKED	40	6	3,328		9	789	6
7	17	ADMIN. COMP - H. WENGROW	AVG. HOURS WORKED	65	6	173,652	173,652	5	13,358	7
8	17	ADMIN. COMP - J. WEBSTER	AVG. HOURS WORKED	70	6	194,652	194,652	20	55,615	8
9	27	EMP. BEN. - H. WENGROW	AVG. HOURS WORKED	65	6	12,114		5	932	9
10	27	EMP. BEN. - J. WEBSTER	AVG. HOURS WORKED	70	6	12,481		20	3,566	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					\$ 467,329	\$ 434,918		\$ 95,677	25

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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					\$	\$		\$	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	223,823	6	1,550	53,066	367	2
3	26	INSURANCE	PATIENT DAYS	223,823	6	2,342	53,066	555	3
4	30	DEPRECIATION	PATIENT DAYS	223,823	6	12,254	53,066	2,905	4
5	32	INTEREST EXPENSE	PATIENT DAYS	223,823	6	9,684	53,066	2,296	5
6	19	RE TAX PROFESSIONAL FEES	PATIENT DAYS	223,823	6		53,066		6
7	33	REAL ESTATE TAXES	PATIENT DAYS	223,823	6	25,161	53,066	5,965	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					\$ 50,991	\$	\$ 12,089	25

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number Atrium Health Care Center

0033977 Report Period Beginning: 01/01/15 Ending: 12/31/15

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

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending: 12/31/15

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

Facility Name & ID Number

Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	\$41,146.00		\$ 5,937,163	\$ 4,636,449		\$ 158,789	1								
2	Allocated from Double You		X	Mortgage						2,296	2								
3											3								
4											4								
5											5								
Working Capital																			
6	MB Financial		X	Loan Payable				65,233		3,224	6								
7											7								
8											8								
9	TOTAL Facility Related				\$41,146.00		\$ 5,937,163	\$ 4,701,682		\$ 164,309	9								
B. Non-Facility Related*																			
10	Interest Income		X							(2,281)	10								
11											11								
12											12								
13											13								
14	TOTAL Non-Facility Related						\$	\$		\$ (2,281)	14								
15	TOTALS (line 9+line14)						\$ 5,937,163	\$ 4,701,682		\$ 162,028	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.)

** 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:

01/01/15

Ending:

12/31/15

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																			
	Working Capital																			
8							\$	\$			\$	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.)

2014 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 Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>11-32-105-005-0000</u>	<u>Long Term Care Property</u>	\$ <u>3,369.01</u>	\$ <u>3,369.01</u>
2. <u>11-32-105-006-0000</u>	<u>Long Term Care Property</u>	\$ <u>49,178.61</u>	\$ <u>49,178.61</u>
3. <u>11-32-105-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>93,821.93</u>	\$ <u>93,821.93</u>
4. <u>11-32-105-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>48,846.72</u>	\$ <u>48,846.72</u>
5. <u>10-35-329-014-0000</u>	<u>Home Office</u>	\$ <u>25,158.55</u>	\$ <u>5,964.82</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>220,374.82</u>	\$ <u>201,181.09</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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:

01/01/15

Ending:

12/31/15

X. BUILDING AND GENERAL INFORMATION:

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

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

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

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____

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

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 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>11,854</u>	<u>2</u>
3	TOTALS	26,895		\$ 136,566	3

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	\$ 162,204	33	\$ 26,504	\$ (135,700)	\$ 945,910	4
5			1972	344,971		20				5
6										6
7										7
8										8
Improvement Type**										
9	Various		1972	50,343		20			50,343	9
10	Various		1974	12,941		20			12,941	10
11	Various		1977	46,500		20			46,500	11
12	Various		1978	23,362		20			23,362	12
13	Various		1979	11,676		20			11,676	13
14	Various		1980	12,652		20			12,652	14
15	Various		1981	4,095		20			4,095	15
16	Various		1982	1,310		20			1,310	16
17	Various		1989	42,200		20			42,200	17
18	Various		1992	16,375		20			16,375	18
19	Various		1993	26,090		20			26,095	19
20	Various		1995	32,183		20	1,038	1,038	31,833	20
21	Various		1996	71,604		20	3,580	3,580	70,113	21
22	Various		1997	52,684		20	2,634	2,634	49,116	22
23	Various		1998	131,108		20	6,555	6,555	115,693	23
24	Various		1999	9,413		20	471	471	7,703	24
25	Various		2000	67,328		20	2,047	2,047	38,905	25
26	Various		2001	13,010		20	651	651	9,549	26
27	Various		2002	5,102		20			5,102	27
28	Various		2003	55,595		20	1,113	1,113	50,037	28
29	Various		2004	7,347		20	223	223	5,486	29
30	Various		2005	15,308		20	539	539	13,935	30
31	Various		2006	47,619		20	4,181	4,181	39,908	31
32	Various		2007	6,765		20	338	338	3,016	32
33	Various		2008	48,015		20	2,477	2,477	39,361	33
34	Various		2009	87,312		20	8,731	8,731	57,950	34
35	Various		2010	52,946		20	5,009	5,009	27,169	35
36	Various		2011	25,166		20	3,072	3,072	13,799	36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending:

12/31/15

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			118,562	2,906	3,168	262	40,947	68
69				13,858		(13,858)		69
70		\$	2,014,436	\$	72,332	\$	1,813,080	70

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 2,014,436	\$ 178,968		\$ 72,332	\$ (106,636)	\$ 1,813,080	1
2	Vinyl Tile In 3Rd Floor Corridor	2012	20,209		20	4,042	4,042	14,146	2
3	Remove And Install Flooring	2012	34,979		20	6,996	6,996	25,068	3
4	Vinyl Tile In 2Nd Floor Corridor	2012	20,209		20	4,042	4,042	13,809	4
5	Ceiling Light Fixtures For 1St, 2Nd, 3Rd Floors	2012	63,206		20	6,321	6,321	24,229	5
6	Wallcovering	2012	10,115		20	506	506	2,023	6
7	Chiller	2013	120,583		20	12,058	12,058	31,151	7
8	Walk-In Cooler Repair	2013	2,818		20	141	141	423	8
9	Sprinkler System - Replace Hose, Relief & Butterfly Valve	2014	3,150		20	188	188	297	9
10	Controls & Parts To Install Fire Pump Annunciator	2014	2,716		20	136	136	215	10
11	Lintel Replacement / Tuckpointing	2014	34,944		20	1,747	1,747	1,893	11
12	Walk-In Cooler	2015	2,516		20	126	126	126	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)		\$ 2,329,881	\$ 178,968		\$ 108,633	\$ (70,335)	\$ 1,926,460	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,329,881	\$ 178,968		\$ 108,633	\$ (70,335)	\$ 1,926,460	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		\$ 2,329,881	\$ 178,968		\$ 108,633	\$ (70,335)	\$ 1,926,460	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,329,881	\$ 178,968		\$ 108,633	\$ (70,335)	\$ 1,926,460	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		\$ 2,329,881	\$ 178,968		\$ 108,633	\$ (70,335)	\$ 1,926,460	34

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

XI. OWNERSHIP COSTS (continued)

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

1	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		\$ 2,329,881	\$ 178,968		\$ 108,633	\$ (70,335)	\$ 1,926,460	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		\$ 2,329,881	\$ 178,968		\$ 108,633	\$ (70,335)	\$ 1,926,460	34

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

XI. OWNERSHIP COSTS (continued)

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		\$	\$		\$	\$	\$	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	TOTAL (lines 1 thru 33)		\$	\$		\$	\$	\$	34

**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:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

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

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

**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		\$	\$		\$	\$	\$	1
2	Buildings:								2
3	Allocated from Double You	2003	113,313	2,906	20	2,906		37,651	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from StayCare	2003	5,249		20	262	262	3,296	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)		\$ 118,562	\$ 2,906		\$ 3,168	\$ 262	\$ 40,947	34

**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:

01/01/15

Ending:

12/31/15

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		\$ 118,562	\$ 2,906		\$ 3,168	\$ 262	\$ 40,947	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)	\$ 118,562	\$ 2,906		\$ 3,168	\$ 262	\$ 40,947	34

**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:

01/01/15

Ending:

12/31/15

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 143,801	\$	\$ 19,045	\$ 19,045	10	\$ 90,870	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	997,411				10	997,411	73
74								74
75	TOTALS	\$ 1,141,212	\$	\$ 19,045	\$ 19,045		\$ 1,088,281	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 Manager	2012	\$ 8,024	\$ 549	\$ 1,033	\$ 484	5	\$ 4,236	76
77										77
78										78
79										79
80	TOTALS			\$ 8,024	\$ 549	\$ 1,033	\$ 484		\$ 4,236	80

E. Summary of Care-Related Assets

	1	2		
	Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,615,683	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 179,517	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 128,711	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (50,806)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,018,977	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? YES NO

If NO, see instructions.

		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		\$	\$ 8,601	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 8,601	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. 2016 \$ _____

13. 2017 \$ _____

14. 2018 \$ _____

* 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.

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost													
1	Licensed Occupational Therapist	39 - 03	hrs	\$			\$	107,680	\$			\$	107,680			1	
2	Licensed Speech and Language Development Therapist	39 - 03	hrs					31,405								31,405	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39 - 03	hrs					115,650								115,650	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								44,011					44,011	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>										1,124					1,124	13
14	TOTAL			\$				\$	255,859	\$	44,011	\$		\$	299,870		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.

Facility Name & ID Number Atrium Health Care Center# 0033977Report Period Beginning: 01/01/15Ending: 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15

(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	\$ 994,569	\$ 1,239,518	1
2	Cash-Patient Deposits	113,652	113,652	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	1,156,600	1,156,600	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	193,605	193,605	6
7	Other Prepaid Expenses	2,985	2,985	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,461,411	\$ 2,706,360	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		260,000	13
14	Buildings, at Historical Cost		4,460,623	14
15	Leasehold Improvements, at Historical Cost	912,933	912,933	15
16	Equipment, at Historical Cost	373,209	853,209	16
17	Accumulated Depreciation (book methods)	(948,171)	(5,057,496)	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):		428,666	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 337,971	\$ 1,857,935	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,799,382	\$ 4,564,295	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 251,554	\$ 251,553	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	113,523	113,523	28
29	Short-Term Notes Payable	65,233	65,233	29
30	Accrued Salaries Payable	178,554	178,554	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,932	1,932	31
32	Accrued Real Estate Taxes(Sch.IX-B)	204,977	204,977	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	See Attached Schedule	186,195	186,195	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,001,968	\$ 1,001,967	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,636,449	40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	See Attached Schedule	932,666	932,666	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 932,666	\$ 5,569,115	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,934,634	\$ 6,571,082	46
47	TOTAL EQUITY(page 18, line 24)	\$ 864,748	\$ (2,006,787)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,799,382	\$ 4,564,295	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,613,668	1
2	Restatements (describe):		2
3	<u>Rounding</u>	(5)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,613,663	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	555,085	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,304,000)	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)	\$ (748,915)	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)	\$ 864,748	24 *

* This must agree with page 17, line 47.

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	\$ 9,614,175	1
2	Discounts and Allowances for all Levels	(1,600,485)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,013,690	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	562,121	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 562,121	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	51,725	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	2,426	19
20	Radiology and X-Ray		20
21	Other Medical Services	3,985	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 58,136	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	2,281	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,281	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	4,800	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,800	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,641,028	30

2

II. Expenses		Amount	
A. Operating Expenses			
31	General Services	1,207,313	31
32	Health Care	2,088,763	32
33	General Administration	1,575,856	33
B. Capital Expense			
34	Ownership	2,516,346	34
C. Ancillary Expense			
35	Special Cost Centers	299,870	35
36	Provider Participation Fee	397,795	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,085,943	40
41	Income before Income Taxes (line 30 minus line 40)**	555,085	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 555,085	43

III. Net Inpatient Revenue detailed by Payer Source		Amount	
44	Medicaid - Net Inpatient Revenue	\$ 7,254,833	44
45	Private Pay - Net Inpatient Revenue	87,571	45
46	Medicare - Net Inpatient Revenue	652,070	46
47	Other-(specify) Veterans	19,216	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,013,690	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.

Facility Name & ID Number Atrium Health Care Center

0033977

Report Period Beginning:

01/01/15

Ending:

12/31/15

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	3,873	4,263	\$ 166,166	\$ 38.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	7,231	8,028	227,065	28.28	3
4	Licensed Practical Nurses	23,343	26,410	595,354	22.54	4
5	CNAs & Orderlies	44,934	53,126	523,474	9.85	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,885	2,119	24,548	11.58	8
9	Activity Director	1,893	2,007	25,502	12.71	9
10	Activity Assistants	5,142	5,557	55,006	9.90	10
11	Social Service Workers	6,263	6,587	135,679	20.60	11
12	Dietician					12
13	Food Service Supervisor	1,864	2,173	38,592	17.76	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,202	19,720	206,975	10.50	15
16	Dishwashers					16
17	Maintenance Workers	3,680	4,116	95,734	23.26	17
18	Housekeepers	17,341	19,118	192,282	10.06	18
19	Laundry	5,840	6,266	68,791	10.98	19
20	Administrator	1,968	2,056	102,555	49.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,884	7,406	82,073	11.08	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	827	929	15,626	16.82	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	5,572	6,085	196,723	32.33	33
34	TOTAL (lines 1 - 33)	156,742	175,966	\$ 2,752,145 *	\$ 15.64	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	\$ 11,146	01-03	35
36	Medical Director	Monthly	24,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,798	10-03	39
40	Physical Therapy Consultant	32	1,575	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	531	11-03	44
45	Social Service Consultant	46	2,552	12-03	45
46	Other(specify)				46
47	<u>Religious Services</u>	Monthly	3,300	12-03	47
48	<u>RUG Consultant</u>	Monthly	18,000	10-03	48
49	TOTAL (lines 35 - 48)	88	\$ 71,902		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

Facility Name & ID Number Atrium Health Care Center# 0033977

Report Period Beginning:

01/01/15

Ending:

12/31/15**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 - \$17,280
- (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. \$ 25,593 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. \$ 397,795
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. \$ 41,004 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% ln 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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.

Page 24

Atrium Health Care Center

#0033977

12/31/2015

Selected Disclosure

In or about August 2015, Atrium Health Care Center ("Atrium") received a Civil Investigative Demand ("CID") from the United States Department of Justice ("DOJ"). Atrium has provided documents to DOJ in response to this CID. As of the date of the certification by the authorized facility officer of this cost report, no allegations of wrongdoing have been made against Atrium and there has been no claim for damages to date.

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