FOR BHF USE

LL1

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

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0048645

Facility Name: ATRIUM HC & REHAB CTR OF CAHOKIA

Address: 3354 JEROME LANE (Number) CAHOKIA (City) 62206 (Zip Code)

County: ST. CLAIR

Telephone Number: (618) 337-9400 **Fax #** (618) 332-1811

HFS ID Number:

Date of Initial License for Current Owners: 05/01/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2011 to 12/31/2011 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) MARTIN WEISS
(Title) MEMBER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, VICE PRESIDENT
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3	84	Intermediate (ICF)	84	30,660	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	133	TOTALS	133	48,545	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,824	4,824	8
9	SNF/PED					9
10	ICF	39,952	508	112	40,572	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,952	508	4,936	45,396	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.51%

D. How many bed-hold days during this year were paid by the Department?
0 (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 [X]

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

I. On what date did you start providing long term care at this location?
Date started 05/01/2000

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/2000 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 49 and days of care provided 4,824

Medicare Intermediary MUTUAL OF OMANA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKI/ # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	169,817	22,564	11,886	204,267		204,267	6,432	210,699			1
2	Food Purchase		281,592		281,592		281,592	(18)	281,574			2
3	Housekeeping	176,843	28,958		205,801		205,801		205,801			3
4	Laundry	115,968	24,977		140,945		140,945		140,945			4
5	Heat and Other Utilities			128,327	128,327		128,327		128,327			5
6	Maintenance	64,072	33,592	11,458	109,122		109,122		109,122			6
7	Other (specify):*			17,781	17,781		17,781		17,781			7
8	**TOTAL General Services**	526,700	391,683	169,452	1,087,835		1,087,835	6,414	1,094,249			8
	B. Health Care and Programs											
9	Medical Director			7,900	7,900		7,900		7,900			9
10	Nursing and Medical Records	1,628,342	184,684	75,930	1,888,956		1,888,956	(17,570)	1,871,386			10
10a	Therapy	92,332		2,133	94,465		94,465		94,465			10a
11	Activities	106,559	3,295		109,854		109,854		109,854			11
12	Social Services	182,325	1,413	2,695	186,433		186,433		186,433			12
13	CNA Training											13
14	Program Transportation			3,288	3,288		3,288		3,288			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,009,558	189,392	91,946	2,290,896		2,290,896	(17,570)	2,273,326			16
	C. General Administration											
17	Administrative	87,413		404,000	491,413		491,413	(41,156)	450,257			17
18	Directors Fees											18
19	Professional Services			380,495	380,495		380,495	(293,778)	86,717			19
20	Dues, Fees, Subscriptions & Promotions			48,115	48,115		48,115	(26,104)	22,011			20
21	Clerical & General Office Expenses	111,687	20,484	34,713	166,884		166,884	14,287	181,171			21
22	Employee Benefits & Payroll Taxes			428,633	428,633		428,633		428,633			22
23	Inservice Training & Education			75	75		75	520	595			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			17,907	17,907		17,907	4,382	22,289			25
26	Insurance-Prop.Liab.Malpractice			128,050	128,050		128,050	2,005	130,055			26
27	Other (specify):*							21,418	21,418			27
28	**TOTAL General Administration**	199,100	20,484	1,441,988	1,661,572		1,661,572	(318,426)	1,343,146			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,735,358	601,559	1,703,386	5,040,303		5,040,303	(329,582)	4,710,721			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.

Facility Name & ID#: ATRIUM HC & REHAB CTR OF CAHOKIA #0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	11,549	
	REPAIRS & MAINTENANCE		337	
			0	11,886
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		8,430	
	ELECTRICITY		69,011	
	WATER		47,971	
	CABLE TV - LOBBY		2,915	
			0	128,327
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,871	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		2,052	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		4,535	
			0	
			0	
			0	
			0	11,458
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		17,781	
	SECURITY SERVICE		0	
			0	
			0	17,781
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,900	7,900

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	2,698	
	PHARMACY CONSULTANT	XVIII B 39-2	1,232	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	72,000	
			0	
			0	75,930
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	981	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	521	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	631	
				2,133
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,695	
	SOCIAL WORKER	XVIII B 45-2	0	
				2,695
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA **#0048645** **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		3,288	3,288
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	404,000	404,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	35,148	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	45,347	
	BOOKKEEPING/ ADMINISTRATIVE SERVICES		300,000	380,495
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	21,684	
	EMPLOYEE WANT ADS	XIX F	3,290	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,553	
	LICENSES & PERMITS	XIX F	5,408	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	4,637	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,143	
	PATIENT BACKGROUND CHECKS	XIX F	2,400	
				48,115
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		429	
	EQUIPMENT REPAIR & MAINTENANCE		4,669	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	10,530	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		15,656	
	MESSENGER SERVICE		3,429	
			0	34,713

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	212,266	
	UNEMPLOYMENT COMPENSATION	XIX D	112,303	
	WORKERS COMPENSATION INSURANC	XIX D	68,811	
	HOSPITALIZATION INSURANCE	XIX D	27,451	
	EMPLOYEE BENEFITS - OTHER	XIX D	7,802	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	
			0	428,633
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		75	
				75
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		17,907	
				17,907
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		128,050	
				128,050
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER **1,703,386**

ATRIUM HC & REHAB CTR OF CAHOKIA
SCHEDULES
12/31/2011

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	281,592
LESS SALES TAX	(18)
NET FOOD	281,574
TOTAL PATIENT CENSUS	45,396
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	136,188
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	136,188
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	136,188
NET FOOD	281,574
DIVIDE TOTAL MEALS/YEAR	136,188
COST PER MEAL	2.07
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**
	========

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA #0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			87,011	87,011		87,011	(25,069)	61,942			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			16,497	16,497		16,497	(148)	16,349			32
33	Real Estate Taxes			43,762	43,762		43,762		43,762			33
34	Rent-Facility & Grounds			391,934	391,934		391,934	5,085	397,019			34
35	Rent-Equipment & Vehicles			11,239	11,239		11,239	11,323	22,562			35
36	Other (specify):*											36
37	TOTAL Ownership			550,443	550,443		550,443	(8,809)	541,634			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		95,736	611,004	706,740		706,740		706,740			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,818	72,818		72,818		72,818			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		95,736	683,822	779,558		779,558		779,558			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,735,358	697,295	2,937,651	6,370,304		6,370,304	(338,391)	6,031,913			45

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(26,101)	30		9
10	Interest and Other Investment Income	(148)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(18)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(10,530)	21		18
19	Entertainment		20		19
20	Contributions	(4,637)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(21,684)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(42,406)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (105,524)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(232,867)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (232,867)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (338,391)		37

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

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

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

ATRIUM HC & REHAB CTR OF CAHOKIA

ID# 0048645

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SLARIES	$ -42,406	21	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
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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**	(42,406)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	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)	
	A. General Services													
1	Dietary	0	0	6,432	0	0	0	0	0	0	0	0	6,432	1
2	Food Purchase	(18)	0	0	0	0	0	0	0	0	0	0	(18)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(18)	0	6,432	0	0	0	0	0	0	0	0	6,414	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(72,000)	54,430	0	0	0	0	0	0	0	0	(17,570)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(72,000)	54,430	0	0	0	0	0	0	0	0	(17,570)	16
	C. General Administration													
17	Administrative	0	(404,000)	362,844	0	0	0	0	0	0	0	0	(41,156)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(300,000)	6,222	0	0	0	0	0	0	0	0	(293,778)	19
20	Fees, Subscriptions & Promotions	(26,321)	0	217	0	0	0	0	0	0	0	0	(26,104)	20
21	Clerical & General Office Expenses	(52,936)	0	67,223	0	0	0	0	0	0	0	0	14,287	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	520	0	0	0	0	0	0	0	0	520	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	4,382	0	0	0	0	0	0	0	0	4,382	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,005	0	0	0	0	0	0	0	0	2,005	26
27	Other (specify):*	0	0	21,418	0	0	0	0	0	0	0	0	21,418	27
28	**TOTAL General Administration**	(79,257)	(704,000)	464,831	0	0	0	0	0	0	0	0	(318,426)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(79,275)	(776,000)	525,693	0	0	0	0	0	0	0	0	(329,582)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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	(26,101)	0	1,032	0	0	0	0	0	0	0	0	(25,069)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(148)	0	0	0	0	0	0	0	0	0	0	(148)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	5,085	0	0	0	0	0	0	0	0	5,085	34
35	Rent-Equipment & Vehicles	0	0	11,323	0	0	0	0	0	0	0	0	11,323	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(26,249)	0	17,440	0	0	0	0	0	0	0	0	(8,809)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(105,524)	(776,000)	543,133	0	0	0	0	0	0	0	0	(338,391)	45

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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
MARTIN J. WEISS	30.00	BELLEVILLE HEALTHCARE & REHAB CENTER	BELLEVILLE	WEISS MGMT	SKOKIE	MGMT/CLERICAL
NATAN WEISS	30.00			GROUP		
DANIEL WEISS	30.00	PALOS HILLS HEALTHCARE	PALOS HILLS			
GARY A. WEINTRAUB	10.00					
		GENEVA NURSING & REHAB CENTER	GENEVA			

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	NURSING CONSULTANT	$ 72,000	WEISS MANAGEMENT GROUP		$	$ (72,000)	1
2	V	17	MANAGEMENT FEES	404,000				(404,000)	2
3	V	19	ADMIN./BKKP. FEES	300,000				(300,000)	3
4	V								4
5	V								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			$ 776,000			$	$ * (776,000)	14

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$	WEISS MANAGEMENT GROUP		$ 6,432	$ 6,432	15
16	V	10	NURSING SALARIES				54,430	54,430	16
17	V	17	ADMINISTRATIVE SALARIES				362,844	362,844	17
18	V	19	PROFESSIONAL FEES				6,222	6,222	18
19	V	20	LICENSES & PERMITS				217	217	19
20	V	21	OFFICE EXPENSES				67,223	67,223	20
21	V	23	SEMINARS				520	520	21
22	V	25	TRANSPORTATION STAFF				4,382	4,382	22
23	V	26	INSURANCE				2,005	2,005	23
24	V	27	EMPLOYEE BENEFITS				21,418	21,418	24
25	V	30	DEPRECIATION (SL)				1,032	1,032	25
26	V	34	OFFICE RENT				5,085	5,085	26
27	V	35	AUTO LEASE				11,323	11,323	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			$			$ 543,133	$ * 543,133	39

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKI # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARTIN WEISS	PRESIDENT	ADMINISTRATIC	30.00		20	50.00	SALARY	$ 108,101	17-7	1
2					SEE						2
3	DANIEL WEISS	MANAGER	MANAGEMENT	30.00	ATTACHED	8	20.00	SALARY	137,970	17-7	3
4					SCHEDULE						4
5	NATAN WEISS	CFO	FINANCE/MGMT	30.00		10	25.00	SALARY	116,773	17-7	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 362,844		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 HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

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 [X] NO [ ]

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

Name of Related Organization: WEISS MANAGEMENT GROUP
Street Address: 3856 OAKTON
City / State / Zip Code: SKOKIE
Phone Number: (847) 933-9200
Fax Number: (847) 972-2168

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT CENSUS	158,674	4	$ 22,482	$ 22,482	45,396	$ 6,432	1
2	10	NURSING SALARIES	PATIENT CENSUS	158,674	4	190,250	190,250	45,396	54,430	2
3	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	158,674	4	1,268,260	1,268,260	45,396	362,844	3
4	19	PROFESSIONAL FEES	PATIENT CENSUS	158,674	4	21,748		45,396	6,222	4
5	20	LICENSES & PERMITS	PATIENT CENSUS	158,674	4	757		45,396	217	5
6	21	OFFICE EXPENSES	PATIENT CENSUS	158,674	4	234,967	179,529	45,396	67,223	6
7	23	SEMINARS	PATIENT CENSUS	158,674	4	1,816		45,396	520	7
8	25	TRANSPORTATION STAFF	PATIENT CENSUS	158,674	4	15,315		45,396	4,382	8
9	26	INSURANCE	PATIENT CENSUS	158,674	4	7,007		45,396	2,005	9
10	27	EMPLOYEE BENEFITS	PATIENT CENSUS	158,674	4	74,863		45,396	21,418	10
11	30	DEPRECIATION (SL)	PATIENT CENSUS	158,674	4	3,607		45,396	1,032	11
12	34	OFFICE RENT	PATIENT CENSUS	158,674	4	17,775		45,396	5,085	12
13	35	AUTO LEASE	PATIENT CENSUS	158,674	4	39,578		45,396	11,323	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					$ 1,898,425	$ 1,660,521		$ 543,133	25

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKI/ # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5		X		WORKING CAPITAL	DEMAND	05/08/11	2,000,000	969,139		PRIME+	8,588	5
	Working Capital											
6	BANK FINANCIAL	X		W/C LOAN	$5,894.04	05/14/07	300,000	61,622	04/11	3.7500	3,974	6
7	US BANK	X		AUTO LOAN	$749.80	02/08	37,400	9,950	02/13	7.5000	1,067	7
8		X		INSURANCE FINANCING							2,868	8
9	TOTAL Facility Related				$6,643.84		$ 2,337,400	$ 1,040,711			$ 16,497	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,337,400	$ 1,040,711			$ 16,497	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # 36

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

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		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.)	$	43,762	2
3. Under or (over) accrual (line 2 minus line 1).	$	43,762	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	43,762	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	49,290	8
	2007	54,288	9
	2008	61,061	10
	2009	44,479	11
	2010	43,762	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2010 TAX BILL.

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

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ATRIUM HC & REHAB CTR OF CAHOKIA COUNTY ST. CLAIR

FACILITY IDPH LICENSE NUMBER 0048645

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

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

Enter the tax index number and real estate tax assessed for 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-12.0-206-016	NURSING HOME	$ 43,762.26	$ 43,762.26
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 43,762.26	$ 43,762.26

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X 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 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,723 B. General Construction Type: Exterior BRICK Frame MASONRY Number of Stories 1

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

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

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] 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				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2006	30,000	1,091	27.5	1,091		5,655	9
10	AIR CONDITIONS			2006	947	91	5	91		983	10
11	INSTALLATION OF EXAUST SYSTEM			2007	3,340	121	27.5	121		600	11
12	AIR CONDITIONS			2007	11,065	1,275	5	1,275		10,428	12
13	INSTALLATION OF ROOFTOP UNIT			2007	4,140	151	27.5	151		698	13
14	CALLCARE STATION REPLACEMENT			2007	3,122	114	27.5	114		518	14
15	EXCAVATE AND REPAIR DRIVEWAY, RENOVATION PATIO			2007	6,870	458	15	458		1,870	15
16	INSTALLATION OF DOORS-FRONT ENTRANCE,VESTIBULE			2007	11,640	423	27.5	423		1,745	16
17	PAINTING			2007	7,587	874	5	874		7,150	17
18	WINDOW TREATMENTS AND CUBICLE CURTAINS			2007	14,027	1,616	5	1,616		13,219	18
19	BUILDING RENOVATION AND REMODELING:			2007	228,253	8,300	27.5	8,300		33,546	19
20	A,B,C,D-WINGS CORRIDOR,RISIDENT ROOMS, THERAPY										20
21	ROOM,LOBBY, RECEPTION,ACTIVITY ROOM, HALL-LIGHT										21
22	FIXTURES,FLOORING,CEILING GRID & TILE,HANDRAILS,										22
23	CORNER GUARDS,NURSES STATION B-WING CORRIDOR										23
24	D-WING RESIDENT ROOM-FLOORING			2008	34,382	1,250	27.5	1,250		4,740	24
25	SHOWER-VARIOUS DIFFERENT AREAS			2008	16,266	591	27.5	591		2,192	25
26	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2008	26,400	960	27.5	960		3,400	26
27	INSTALLED NEW OFFICE, SIDEWALK TO THE OFFICE			2008	29,175	1,061	27.5	1,061		3,758	27
28	INSTALLATION OF ALARM SYSTEM			2008	42,875	1,559	27.5	1,559		5,392	28
29	INSTALLATION OF DOORS-OXYGEN ROOM, COURTYARD			2008	6,147	224	27.5	224		793	29
30	AIR CONDITIONS, WATER HEATER			2008	5,513	635	5	635		4,560	30
31	REPLACE EXISTING SPRINKLER PIPING			2008	9,498	345	27.5	345		1,078	31
32	SEALING PARKING LOT			2008	2,500	167	15	167		557	32
33	WALL AIR CONDITIONS			2009	6,308	606	5	606		5,400	33
34	WANDERGUARD E. STANDARD, BUMPER GUARD			2009	10,612	386	27.5	386		852	34
35	LOUNGE,RESIDENT & ACTIVITY ROOMS-FLOORING			2010	16,410	597	27.5	597		1,169	35
36	WALL AIR CONDITIONS			2010	6,712	1,141	5	1,141		5,000	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 HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	
37	INSTALL DOORS AND HARDWARE	2010	$ 2,966	$ 108	27.5	$ 108	$	$ 158	37
38	INSTALL ACCELERATOR, REPLACE DRY PENDENT	2010	3,218	117	27.5	117		171	38
39	RANCH STYLE GARAGE	2010	15,515	564	27.5	564		776	39
40	NEW LAUNDRY ROOM-INSTALL DOORS,CONCRETE SLAB,	2010	28,249	1,027	27.5	1,027		1,070	40
41	FOOTING FOR PERMIT,ELECTRICAL,WIRING,WINDOW,TILE								41
42	WALL AIR CONDITIONS	2011	6,639	6,639	5	1,343	(5,296)	1,343	42
43	SEAL COATING PARKING LOT	2011	20,931	1,163	15	1,163		1,163	43
44	INSTALLED QUARTER BARREL STYLE AWNINGS	2011	2,955	76	27.5	76		76	44
45	RESIDENT ROOMS-CUSTOM BUILT-IN WARDROBES	2011	18,278	471	27.5	471		471	45
46	INSTALL RTU & DUST RUN FROM ATTIC INTO ADM OFFICI	2011	12,989	177	27.5	177		177	46
47	SHOWER ROOM: FOUR PIESE FIBERGLASS SHOWER;	2011	12,163	92	27.5	92		92	47
48	FULL PLYWOOD BACKING ON ALL WALLS; POLYESTER								48
49	GELCOAT FINISH								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									68
69									69
70	TOTAL (lines 4 thru 69)		$ 657,692	$ 34,470		$ 29,174	$ (5,296)	$ 120,800	70

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	$ 149,713	$ 21,032	$ 16,708	$ (4,324)	8-10	$ 47,637	71
72	Current Year Purchases	17,010	17,010	851	(16,159)	3-10	851	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		1,032	1,032				74
75	TOTALS	$ 166,723	$ 39,074	$ 18,591	$ (20,483)		$ 48,488	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	FACILITY	2008 FORD WAGON	2008	$ 37,400	$ 1,775	$ 7,480	$ 5,705	5	$ 29,920	76
77										77
78	ADMINISTRATIVE	2007 LAND ROVER/RANGE	2010	33,484	12,724	6,697	(6,027)	5	13,394	78
79										79
80	TOTALS			$ 70,884	$ 14,499	$ 14,177	$ (322)		$ 43,314	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)	$ 895,299	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,043	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 61,942	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (26,101)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 212,602	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.

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: RIVER BLUFF

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. [X] 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:		133	09/01/06	$ 391,934	15		3
4	Additions							4
5								5
6								6
7	TOTAL		133		$ 391,934 **			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: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 09/01/06
Ending 09/01/21

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	09/01/2012	$ 435,696
13.	09/01/2013	$ 465,696
14.	09/01/2013	$ 465,696

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,239 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

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

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 219,164	$		$ 219,164	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			48,725			48,725	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			343,115			343,115	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				84,547		84,547	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): LABORATORY	39-2					5,633		5,633	12
13	Other (specify): RADIOLOGY	39-2					5,556		5,556	13
14	TOTAL			$		$ 611,004	$ 95,736		$ 706,740	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 HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2011 (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	$ (118,006)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,845,879		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,600		6
7	Other Prepaid Expenses	15,121		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,840,594	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	657,692		15
16	Equipment, at Historical Cost	237,607		16
17	Accumulated Depreciation (book methods)	(297,104)		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):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 598,195	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,438,789	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 588,574	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,050,153		29
30	Accrued Salaries Payable	59,240		30
31	Accrued Taxes Payable (excluding real estate taxes)	28,478		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,726,445	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,726,445	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,712,344	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,438,789	$	48

***(See instructions.)**

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,244,831	1
2	Restatements (describe):		2
3	**PRIOR YEAR ADJUSTMENT**	6,029	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,250,860	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	494,484	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	(33,000)	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)**	$ 461,484	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,712,344	24 *

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,769,311	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,769,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,095,329	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,095,329	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	148	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 148	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,864,788	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,087,835	31
32	Health Care	2,290,896	32
33	General Administration	1,661,572	33
	B. Capital Expense		
34	Ownership	550,443	34
	C. Ancillary Expense		
35	Special Cost Centers	706,740	35
36	Provider Participation Fee	72,818	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,370,304	40
41	**Income before Income Taxes (line 30 minus line 40)****	494,484	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 494,484	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **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 HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,072	$ 64,929	$ 31.34	1
2	Assistant Director of Nursing	1,952	2,024	48,617	24.02	2
3	Registered Nurses	4,921	5,265	144,612	27.47	3
4	Licensed Practical Nurses	27,754	28,770	558,828	19.42	4
5	CNAs & Orderlies	74,194	75,636	675,680	8.93	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,648	9,334	92,332	9.89	8
9	Activity Director					9
10	Activity Assistants	11,346	11,618	106,559	9.17	10
11	Social Service Workers	16,545	17,171	182,325	10.62	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,320	19,224	169,817	8.83	15
16	Dishwashers					16
17	Maintenance Workers	5,005	5,189	64,072	12.35	17
18	Housekeepers	19,640	20,423	176,843	8.66	18
19	Laundry	13,123	13,663	115,968	8.49	19
20	Administrator	1,928	2,080	87,413	42.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,658	8,112	111,687	13.77	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	3,825	4,082	42,475	10.41	31
32	Other Health Ca Care Plan Coord	3,832	4,152	93,201	22.45	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	220,595	228,815	$ 2,735,358 *	$ 11.95	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 11,549	1-3	35
36	Medical Director	O	7,900	9-3	36
37	Medical Records Consultant	N	2,698	10-3	37
38	Nurse Consultant	T	72,000	10-3	38
39	Pharmacist Consultant	H	1,232	10-3	39
40	Physical Therapy Consultant	L	981	10a-3	40
41	Occupational Therapy Consultant	Y	521	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	631	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,695	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 100,207		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Certified Nurse Assistants/Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KENYA WASHINGTON	ADMINISTRATOR	0	$ 87,413
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 87,413

B. Administrative - Other

Description		Amount
WEISS MGMT. GROUP,INC	MANAGEMENT FEES	$ 404,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 404,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		380,495
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 380,495

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,811
Unemployment Compensation Insurance	112,303
FICA Taxes	212,266
Employee Health Insurance	27,451
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	7,802
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 428,633

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	3,290
Health Care Worker Background Check	1,143
(Indicate # of checks performed 114)	
Patient Background Checks 240	2,400
TRUST/FRANCHISE/CONTRIB/ETC	4,637
MARKETING/ADV/PROMO	21,684
LICENSES/DUES/SUBSCRIPTIONS	10,981
MGMT CO ALLOC	217
TRUST/FRANCHISE/CONTRIB/ETC	(4,637)
Less: Public Relations Expense	(0)
Non-allowable advertising	(21,684)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,011

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

**See instructions.

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number ATRIUM HC & REHAB CTR OF CAHOKIA # 0048645 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM CARE $9,453**

(3) Did the nursing home make political contributions or payments to a politica 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?

(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 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,033** Line **10-2**

(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.

(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 fo Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
RIVER BLUFFS OF CAHOKIA NURSING & REHAB CENTER #0042713; 05/01/2000

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen during this cost report period. $ **72,818**
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 tc the Department, in addition to the daily rate, been properly classifiec 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 fo 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. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(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 fo residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
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:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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