FOR BHF USE

LL1

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.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0048645

Facility Name: ATRIUM HC & REHAB CTR-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: SANFORD BOKOR **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 01/01/2013 to 12/31/2013 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) SANFORD BOKOR, PRESIDENT
(Firm Name & Address) KBKB, LTD., 8140 RIVER DRIVE, MORTON GROVE, IL 60053
(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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			5,325	5,325	8
9	SNF/PED					9
10	ICF	37,195	1,166	260	38,621	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,195	1,166	5,585	43,946	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.53%

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 5,325

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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	191,057	19,929	15,678	226,664		226,664	7,174	233,838			1
2	Food Purchase		270,643		270,643		270,643		270,643			2
3	Housekeeping	226,035	39,671		265,706		265,706		265,706			3
4	Laundry	119,943	24,875	2,306	147,124		147,124		147,124			4
5	Heat and Other Utilities			109,526	109,526		109,526	74	109,600			5
6	Maintenance	52,766	43,549	14,154	110,469		110,469	159	110,628			6
7	Other (specify):*			19,134	19,134		19,134		19,134			7
8	**TOTAL General Services**	589,801	398,667	160,798	1,149,266		1,149,266	7,407	1,156,673			8
	B. Health Care and Programs											
9	Medical Director			15,600	15,600		15,600		15,600			9
10	Nursing and Medical Records	1,908,742	239,211	8,663	2,156,616		2,156,616	26,670	2,183,286			10
10a	Therapy	146,543		9,593	156,136		156,136		156,136			10a
11	Activities	123,526	2,051	832	126,409		126,409		126,409			11
12	Social Services	163,680	314	2,563	166,557		166,557		166,557			12
13	CNA Training											13
14	Program Transportation			580	580		580		580			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,342,491	241,576	37,831	2,621,898		2,621,898	26,670	2,648,568			16
	C. General Administration											
17	Administrative	73,060		250,000	323,060		323,060	43,025	366,085			17
18	Directors Fees											18
19	Professional Services			589,295	589,295		589,295	(352,202)	237,093			19
20	Dues, Fees, Subscriptions & Promotions			43,761	43,761		43,761	(16,317)	27,444			20
21	Clerical & General Office Expenses	161,844	19,263	32,836	213,943		213,943	21,234	235,177			21
22	Employee Benefits & Payroll Taxes			535,483	535,483		535,483		535,483			22
23	Inservice Training & Education			10,383	10,383		10,383	472	10,855			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			18,052	18,052		18,052	4,886	22,938			25
26	Insurance-Prop.Liab.Malpractice			132,970	132,970		132,970	2,573	135,543			26
27	Other (specify):*			1,109,943	1,109,943		1,109,943	(1,073,767)	36,176			27
28	**TOTAL General Administration**	234,904	19,263	2,722,723	2,976,890		2,976,890	(1,370,096)	1,606,794			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,167,196	659,506	2,921,352	6,748,054		6,748,054	(1,336,019)	5,412,035			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-CAHOKIA #0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,678	
	REPAIRS & MAINTENANCE		0	
			0	15,678
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,306	
			0	2,306
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		5,937	
	ELECTRICITY		67,049	
	WATER		33,868	
	CABLE TV - LOBBY		2,672	
			0	109,526
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,241	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		802	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		0	
	FIRE SERVICE		8,111	
			0	
			0	
			0	
			0	14,154
7	**OTHER**			
	SCAVENGER & EXTERMINATING SERVICI		19,134	
	SECURITY SERVICE		0	
			0	
			0	19,134
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	15,600	15,600

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	2,023	
	PHARMACY CONSULTANT	XVIII B 39-2	6,640	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	8,663
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	4,467	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	1,885	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	2,039	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	1,202	
				9,593
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	832	
			0	832
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,563	
	SOCIAL WORKER	XVIII B 45-2	0	
				2,563
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA **#0048645** **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		580	580
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	250,000	250,000
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	34,932	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	90,794	
	BOOKKEEPING/ADMINISTRATIVE SERVICE		463,569	589,295
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	16,081	
	EMPLOYEE WANT ADS	XIX F	967	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	8,796	
	LICENSES & PERMITS	XIX F	5,185	
	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	4,781	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F		
	PATIENT BACKGROUND CHECKS	XIX F	7,951	
				43,761
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		617	
	EQUIPMENT REPAIR & MAINTENANCE		12,606	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,035	
	MESSENGER SERVICE		2,578	
			0	32,836

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	240,801	
	UNEMPLOYMENT COMPENSATION	XIX D	90,042	
	WORKERS COMPENSATION INSURANC	XIX D	113,915	
	HOSPITALIZATION INSURANCE	XIX D	70,785	
	EMPLOYEE BENEFITS - OTHER	XIX D	19,940	
	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	535,483
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		10,383	
				10,383
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,052	
				18,052
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		132,970	
				132,970
27	**OTHER**			
	BAD DEBTS	VI 24	1,109,943	
				1,109,943

GRAND TOTAL COLUMN 3 OTHER **2,921,352**

ATRIUM HC & REHAB CTR-CAHOKIA
SCHEDULES
12/31/2013

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

TOTAL FOOD PURCHASE	270,643
LESS SALES TAX	0
NET FOOD	270,643
TOTAL PATIENT CENSUS	43,946
TIMES 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	131,838
ADD # EMPLOYEE MEALS/DAY	0
TIMES # DAYS	365
TOTAL EMPLOYEE MEALS	0
PATIENT MEALS	131,838
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	131,838
NET FOOD	270,643
DIVIDE TOTAL MEALS/YEAR	131,838
COST PER MEAL	2.05
TIMES EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	**0**

HAVE YOU FORGOTTEN TO ENTER SALES TAX ON PAGE 5??

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA #0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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			58,477	58,477		58,477	6,962	65,439			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			31,804	31,804		31,804	(63,891)	(32,087)			32
33	Real Estate Taxes			36,043	36,043		36,043	472	36,515			33
34	Rent-Facility & Grounds			411,653	411,653		411,653	8,158	419,811			34
35	Rent-Equipment & Vehicles			11,490	11,490		11,490	16,005	27,495			35
36	Other (specify):*											36
37	**TOTAL Ownership**			549,467	549,467		549,467	(32,294)	517,173			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,457	665,882	818,339		818,339		818,339			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			307,088	307,088		307,088		307,088			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		152,457	972,970	1,125,427		1,125,427		1,125,427			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,167,196	811,963	4,443,789	8,422,948		8,422,948	(1,368,313)	7,054,635			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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	4,009	30		9
10	Interest and Other Investment Income	(64,022)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		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		21		18
19	Entertainment		20		19
20	Contributions	(4,781)	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	(1,109,943)	27		24
25	Fund Raising, Advertising and Promotional	(16,081)	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	(42,778)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,233,596)		$	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)	(134,717)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (134,717)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,368,313)		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-CAHOKIA

ID# 0048645

Report Period Beginning: 01/01/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARIES	$ (41,598)	21	1
2	TRANSPORTATION STAFF-MARKETING	(1,180)	25	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				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**	(42,778)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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	0	7,174	0	0	0	0	0	0	0	7,174	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	74	0	0	0	0	0	0	0	74	5
6	Maintenance	0	0	0	159	0	0	0	0	0	0	0	159	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	7,407	0	0	0	0	0	0	0	7,407	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	0	0	26,670	0	0	0	0	0	0	0	26,670	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	0	0	26,670	0	0	0	0	0	0	0	26,670	16
	C. General Administration													
17	Administrative	0	(250,000)	293,025	0	0	0	0	0	0	0	0	43,025	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(275,000)	1,279	(78,481)	0	0	0	0	0	0	0	(352,202)	19
20	Fees, Subscriptions & Promotions	(20,862)	0	291	4,254	0	0	0	0	0	0	0	(16,317)	20
21	Clerical & General Office Expenses	(41,598)	0	52,503	10,329	0	0	0	0	0	0	0	21,234	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	0	472	0	0	0	0	0	0	0	472	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(1,180)	0	2,661	3,405	0	0	0	0	0	0	0	4,886	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,673	900	0	0	0	0	0	0	0	2,573	26
27	Other (specify):*	(1,109,943)	0	27,510	8,666	0	0	0	0	0	0	0	(1,073,767)	27
28	**TOTAL General Administration**	(1,173,583)	(525,000)	378,942	(50,455)	0	0	0	0	0	0	0	(1,370,096)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,173,583)	(525,000)	378,942	(16,378)	0	0	0	0	0	0	0	(1,336,019)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 **Report Period Beginning:** 01/01/2013 **Ending:** 12/31/2013

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 TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,009	0	2,417	536	0	0	0	0	0	0	0	6,962	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(64,022)	0	0	131	0	0	0	0	0	0	0	(63,891)	32
33	Real Estate Taxes	0	0	0	472	0	0	0	0	0	0	0	472	33
34	Rent-Facility & Grounds	0	0	2,613	5,545	0	0	0	0	0	0	0	8,158	34
35	Rent-Equipment & Vehicles	0	0	14,315	1,690	0	0	0	0	0	0	0	16,005	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(60,013)	0	19,345	8,374	0	0	0	0	0	0	0	(32,294)	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)	(1,233,596)	(525,000)	398,287	(8,004)	0	0	0	0	0	0	0	(1,368,313)	45

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

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	17	MANAGEMENT FEES	$ 250,000	WEISS MANAGEMENT GROUP		$	$ (250,000)	1
2	V	19	ADMIN./BKKP. FEES	275,000				(275,000)	2
3	V								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			$ 525,000			$	$ * (525,000)	14

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

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	17	ADMINISTRATIVE SALARIES	$	WEISS MANAGEMENT GROUP		$ 293,025	$ 293,025	15
16	V	19	PROFESSIONAL FEES				1,279	1,279	16
17	V	20	LICENSES & PERMITS				291	291	17
18	V	21	OFFICE EXPENSES				52,503	52,503	18
19	V	25	TRANSPORTATION STAFF				2,661	2,661	19
20	V	26	INSURANCE				1,673	1,673	20
21	V	27	EMPLOYEE BENEFITS				27,510	27,510	21
22	V	30	DEPRECIATION (SL)				2,417	2,417	22
23	V	34	OFFICE RENT				2,613	2,613	23
24	V	35	AUTO LEASE				14,315	14,315	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			$			$ 398,287	$ * 398,287	39

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

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	19	BKKPNG/ ADMIN SERVICES	$ 114,650	BRIA HEALTH SERVICES, LLC		$	$ (114,650)	15
16	V	1	DIETARY SALARIES				7,174	7,174	16
17	V	5	UTILITIES				74	74	17
18	V	6	REPAIR/MAINT				159	159	18
19	V	10	NURSING SALARIES				26,670	26,670	19
20	V	19	PROFESSIONAL FEES				36,169	36,169	20
21	V	20	WANT ADS, LICENSES				4,254	4,254	21
22	V	21	TOTAL OFFICE				10,329	10,329	22
23	V	23	SEMINARS				472	472	23
24	V	25	TRANSPORTATIONAL STAFF				3,405	3,405	24
25	V	26	INSURANCE				900	900	25
26	V	27	EMPLOYEE BENEFITS				8,666	8,666	26
27	V	30	DEPRECIATION (SL)				536	536	27
28	V	32	INTEREST				131	131	28
29	V	33	RE TAX				472	472	29
30	V	34	OFFICE RENT				5,545	5,545	30
31	V	35	EQUIPMENT RENTAL				1,690	1,690	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 114,650			$ 106,646	$ * (8,004)	39

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

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	MARTIN J. WEISS	30.00	BELLEVILLE HEALTHCARE & REHAB		WEISS MGMT		MANAGEMENT/	2
3	NATAN WEISS	30.00	CENTER	BELLEVILLE	GROUP, INC	LINCOLNWOOD	CLERICAL	3
4	DANIEL WEISS	30.00						4
5	GARY A. WEINTRAUB	10.00	GENEVA NURSING & REHAB CENTER	GENEVA	BRIA HEALTH		MANAGEMENT	5
6					SERVICES, LLC	LINCOLNWOOD	SERVICES	6
7			MST HEALTH CARE PROPERTIES	SOUTH CHICAGO				7
8				HEIGHTS				8
9								9
10			LAKE PARK CENTER	WAUKEGAN				10
11								11
12			WESTMONT NURSING & REHAB					12
13			CENTER, LLC	WESTMONT				13
14								14
15			FOREST EDGE HEALTHCARE REHAB					15
16			CENTER	CHICAGO				16
17								17
18			RIVER OAKS HEALTHCARE REHAB					18
19			CENTER	BURNHAM				19
20								20
21			PALOS HILLS HEALTHCARE, LLC	PALOS HILLS				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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	ALLOCATIONS FROM WEISS MANAGEMENT GROUP:								$		1
2	MARTIN WEISS	PRESIDENT	ADMINISTRATIO	30.00	SEE	10	22.22	SALARY	97,675	17-7	2
3					ATTACHED						3
4	DANIEL WEISS	MANAGER	MANAGEMENT	30.00	SCHEDULE	15	13.04	SALARY	97,675	17-7	4
5											5
6	NATAN WEISS	CFO	FINANCE/MGMT	30.00		10	13.51	SALARY	97,675	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 293,025		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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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: 6865 N LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	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	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	89,984	2	$ 600,000	$ 600,000	43,946	$ 293,025	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	89,984	2	2,619		43,946	1,279	2
3	20	LICENSES & PERMITS	PATIENT CENSUS	89,984	2	596		43,946	291	3
4	21	OFFICE EXPENSES	PATIENT CENSUS	89,984	2	107,505		43,946	52,503	4
5	25	TRANSPORTATION STAFF	PATIENT CENSUS	89,984	2	5,448		43,946	2,661	5
6	26	INSURANCE	PATIENT CENSUS	89,984	2	3,425		43,946	1,673	6
7	27	EMPLOYEE BENEFITS	PATIENT CENSUS	89,984	2	56,329		43,946	27,510	7
8	30	DEPRECIATION (SL)	PATIENT CENSUS	89,984	2	4,949		43,946	2,417	8
9	34	OFFICE RENT	PATIENT CENSUS	89,984	2	5,350		43,946	2,613	9
10	35	AUTO LEASE	PATIENT CENSUS	89,984	2	29,312		43,946	14,315	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					$ 815,533	$ 600,000		$ 398,287	25

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 2/31/2013

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: BRIA HEALTH SERVICES, LLC
Street Address: 6865 N LINCOLN AVE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	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	475,523	8	$ 77,622	$ 77,622	43,946	$ 7,174	1
2	5	UTILITIES	PATIENT CENSUS	475,523	8	806		43,946	74	2
3	6	REPAIR/MAINT	PATIENT CENSUS	475,523	8	1,722		43,946	159	3
4	10	NURSING SALARIES	PATIENT CENSUS	475,523	8	288,582	288,582	43,946	26,670	4
5	19	PROFESSIONAL FEES	PATIENT CENSUS	475,523	8	391,370	100,000	43,946	36,169	5
6	20	WANT ADS, LICENSES	PATIENT CENSUS	475,523	8	46,030		43,946	4,254	6
7	21	TOTAL OFFICE	PATIENT CENSUS	475,523	8	111,765	36,036	43,946	10,329	7
8	23	SEMINARS	PATIENT CENSUS	475,523	8	5,110		43,946	472	8
9	25	TRANSPORTATIONAL STAFF	PATIENT CENSUS	475,523	8	36,847		43,946	3,405	9
10	26	INSURANCE	PATIENT CENSUS	475,523	8	9,739		43,946	900	10
11	27	EMPLOYEE BENEFITS	PATIENT CENSUS	475,523	8	93,769		43,946	8,666	11
12	30	DEPRECIATION (SL)	PATIENT CENSUS	475,523	8	5,805		43,946	536	12
13	32	INTEREST	PATIENT CENSUS	475,523	8	1,420		43,946	131	13
14	33	RE TAX	PATIENT CENSUS	475,523	8	5,109		43,946	472	14
15	34	OFFICE RENT	PATIENT CENSUS	475,523	8	60,000		43,946	5,545	15
16	35	EQUIPMENT RENTAL	PATIENT CENSUS	475,523	8	18,286		43,946	1,690	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,153,982	$ 502,240		$ 106,646	25

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	RELATED PARTY ALLOCATION										131	5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND	05/08/11	2,000,000	858,993		PRIME+	29,939	6
7	US BANK	X		AUTO LOAN		02/08	37,400		02/13	7.5000	4	7
8		X		INSURANCE FINANCING							1,861	8
9	TOTAL Facility Related						$ 2,037,400	$ 858,993			$ 31,935	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,037,400	$ 858,993			$ 31,935	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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 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.)		$ 36,043	2
3. Under or (over) accrual (line 2 minus line 1).		$ 36,043	3
4. Real Estate Tax accrual used for 2013 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.		$ 36,043	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	61,061	8
	2009	44,479	9
	2010	43,762	10
	2011	40,322	11
	2012	36,043	12

THE PAYMENT ON LINE 2 APPLIES TO THE 2012 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	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.

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ATRIUM HC & REHAB CTR-CAHOKIA COUNTY ST CLAIR

FACILITY IDPH LICENSE NUMBER 0048645

CONTACT PERSON REGARDING THIS REPORT SANFORD BOKOR

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 2012 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 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-12.0-206-016	NURSING HOME	$ 36,043.34	$ 36,043.34
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,043.34	$ 36,043.34

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 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	RELATED PARTY ALLOCATION					390		390			8
	Improvement Type**										
9	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2006	30,000	1,091	27.5	1,091		7,837	9
10	AIR CONDITIONS			2006	947		5			947	10
11	INSTALLATION OF EXAUST SYSTEM			2007	3,340	121	27.5	121		842	11
12	AIR CONDITIONS			2007	11,065		5			11,065	12
13	INSTALLATION OF ROOFTOP UNIT			2007	4,140	151	27.5	151		1,000	13
14	CALLCARE STATION REPLACEMENT			2007	3,122	114	27.5	114		746	14
15	EXCAVATE AND REPAIR DRIVEWAY, RENOVATION PATIC			2007	6,870	458	15	458		2,786	15
16	INSTALLATION OF DOORS-FRONT ENTRANCE,VESTIBULE			2007	11,640	423	27.5	423		2,591	16
17	PAINTING			2007	7,587		5			7,587	17
18	WINDOW TREATMENTS AND CUBICLE CURTAINS			2007	14,027		5			14,027	18
19	BUILDING RENOVATION AND REMODELING:			2007	228,253	8,300	27.5	8,300		50,146	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		7,240	24
25	SHOWER-VARIOUS DIFFERENT AREAS			2008	16,266	591	27.5	591		3,374	25
26	INSTALL A NEW DURO-LAST ROOFING SYSTEM			2008	26,400	960	27.5	960		5,320	26
27	INSTALLED NEW OFFICE, SIDEWALK TO THE OFFICE			2008	29,175	1,061	27.5	1,061		5,880	27
28	INSTALLATION OF ALARM SYSTEM			2008	42,875	1,559	27.5	1,559		8,510	28
29	INSTALLATION OF DOORS-OXYGEN ROOM, COURTYARD			2008	6,147	224	27.5	224		1,241	29
30	AIR CONDITIONS, WATER HEATER			2008	5,513	318	5	318		5,513	30
31	REPLACE EXISTING SPRINKLER PIPING			2008	9,498	345	27.5	345		1,768	31
32	SEALING PARKING LOT			2008	2,500	167	15	167		891	32
33	WALL AIR CONDITIONS			2009	6,308	363	5	363		6,126	33
34	WANDERGUARD E. STANDARD, BUMPER GUARD			2009	10,612	386	27.5	386		1,624	34
35	LOUNGE,RESIDENT & ACTIVITY ROOMS-FLOORING			2010	16,410	597	27.5	597		2,363	35
36	WALL AIR CONDITIONS			2010	6,712	411	5	411		6,096	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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$	$ 374	37
38	INSTALL ACCELERATOR, REPLACE DRY PENDENT	2010	3,218	117	27.5	117		405	38
39	RANCH STYLE GARAGE	2010	15,515	564	27.5	564		1,904	39
40	NEW LAUNDRY ROOM-INSTALL DOORS,CONCRETE SLAB	2010	28,249	1,027	27.5	1,027		3,124	40
41	FOOTING FOR PERMIT,ELECTRICAL,WIRING,WINDOW,TILE								41
42	WALL AIR CONDITIONS	2011	6,639		5	1,328	1,328	3,999	42
43	SEAL COATING PARKING LOT	2011	20,931	1,395	15	1,395		3,953	43
44	INSTALLED QUARTER BARREL STYLE AWNINGS	2011	2,955	107	27.5	107		290	44
45	RESIDENT ROOMS-CUSTOM BUILT-IN WARDROBES	2011	18,278	665	27.5	665		1,801	45
46	INSTALL RTU & DUST RUN FROM ATTIC INTO ADM OFFIC	2011	12,989	472	27.5	472		1,121	46
47	SHOWER ROOM: FOUR PIESE FIBERGLASS SHOWER;	2011	12,163	442	27.5	442		976	47
48	FULL PLYWOOD BACKING ON ALL WALLS; POLYESTER								48
49	GELCOAT FINISH								49
50	WALL AIR CONDITIONS	2012	12,123	1,940	5	1,940		4,365	50
51	INSTALLED 35 GALLON GREASE TRAP IN THE FLOOR	2012	13,900	505	27.5	505		779	51
52	REPLACED PIPE IN ATTIC , INSTALLED COMPRESSOR	2012	12,100	440	27.5	440		605	52
53	WALL AIR CONDITIONS	2013	6,903	4,142	5	4,142		4,142	53
54	SPRINKLERS	2013	91,610	2,082	27.5	2,082		2,082	54
55	CARPET FOR COFFICES AND LOBBY INSET; WALK-OFF								55
56	CARPET; WALL BASE	2013	5,794	580	5	580		580	56
57	PLASTER CEILING-INSTALL 2 EXPANSION JOINTS; ATTIC								57
58	SPACE-RE-INSULATE WITH 6" BLOWN	2013	10,338	16	27.5	16		16	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)		$ 810,460	$ 33,882		$ 35,210	$ 1,328	$ 186,036	70

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

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$ 180,854	$ 9,821	$ 20,156	$ 10,335	3-10	$ 87,927	71
72	Current Year Purchases	14,680	8,808	813	(7,995)	8-10	813	72
73	Fully Depreciated Assets							73
74	RELATED PARTY SL DEPRECIATION		2,563	2,563				74
75	TOTALS	$ 195,534	$ 21,192	$ 23,532	$ 2,340		$ 88,740	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	208	$ 37,400	$ 1,775	$	$ (1,775)	5	$ 37,400	76
77										77
78	ADMINISTRATIVE	2007 LAND ROVER/RANGE	2010	33,484	4,581	6,697	2,116	5	26,788	78
79										79
80	TOTALS			$ 70,884	$ 6,356	$ 6,697	$ 341		$ 64,188	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)	$ 1,076,878	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 61,430	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 65,439	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,009	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 338,964	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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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		$ 411,653			3
4	Additions							4
5								5
6								6
7	TOTAL		133		$ 411,653 **			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
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

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: $ 11,490 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			N/A		18
19					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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	$		$ 252,760	$		$ 252,760	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			93,241			93,241	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			319,881			319,881	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				113,160		113,160	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): RADIOLOGY, LAB	39-2					14,079		14,079	12
13	I.V. THERAPT, Other (specify): MEDICAL SUPPLY	39-2					25,218		25,218	13
14	TOTAL			$		$ 665,882	$ 152,457		$ 818,339	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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (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	$ 161,517	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	1,967,068		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	84,786		6
7	Other Prepaid Expenses	112,272		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,325,643	$	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	810,460		15
16	Equipment, at Historical Cost	266,418		16
17	Accumulated Depreciation (book methods)	(422,570)		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)**	$ 654,308	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,979,951	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 874,512	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,077		28
29	Short-Term Notes Payable	1,008,993		29
30	Accrued Salaries Payable	96,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,623		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)**	$ 2,012,522	$	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)**	$ 2,012,522	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 967,429	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,979,951	$	48

***(See instructions.)**

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,117,595	1	
2	Restatements (describe):		2	
3	**ROUNDING**	(3)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,117,592	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,150,163)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,150,163)	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)**	$ 967,429	24	*

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

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,206,302	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,206,302	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	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***	64,022	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 64,022	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)**	$ 7,270,324	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,149,266	31
32	Health Care	2,621,898	32
33	General Administration	2,976,890	33
	B. Capital Expense		
34	Ownership	549,467	34
	C. Ancillary Expense		
35	Special Cost Centers	818,339	35
36	Provider Participation Fee	307,088	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES - INSURANCE	(2,461)	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,420,487	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,150,163)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,150,163)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 4,033,548	44
45	Private Pay - Net Inpatient Revenue	149,782	45
46	Medicare - Net Inpatient Revenue	2,723,972	46
47	Other-(specify) HOSPICE	212,728	47
48	Other-(specify) MANAGED CARE	86,272	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 7,206,302	49

****TAX RETURN PREPARED ON CASH BASIS**

* **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.**

*** **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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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	1,784	2,054	$ 67,661	$ 32.94	1
2	Assistant Director of Nursing	2,040	2,080	50,064	24.07	2
3	Registered Nurses	4,059	4,255	114,860	26.99	3
4	Licensed Practical Nurses	30,570	32,042	629,499	19.65	4
5	CNAs & Orderlies	85,226	88,505	909,938	10.28	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	10,848	11,859	146,543	12.36	8
9	Activity Director					9
10	Activity Assistants	12,485	13,171	123,526	9.38	10
11	Social Service Workers	14,625	15,307	163,680	10.69	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	19,446	20,489	191,057	9.32	15
16	Dishwashers					16
17	Maintenance Workers	3,577	3,801	52,766	13.88	17
18	Housekeepers	24,253	25,384	226,035	8.90	18
19	Laundry	12,854	13,714	119,943	8.75	19
20	Administrator	1,944	2,080	73,060	35.13	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,063	12,994	161,844	12.46	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	3,709	3,950	40,727	10.31	31
32	Other Health C: Care Plan Coord	3,704	4,080	95,993	23.53	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	243,187	255,765	$ 3,167,196 *	$ 12.38	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	$ 15,678	1-3	35
36	Medical Director	O	15,600	9-3	36
37	Medical Records Consultant	N	2,023	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	6,640	10-3	39
40	Physical Therapy Consultant	L	4,467	10a-3	40
41	Occupational Therapy Consultant	Y	1,885	10a-3	41
42	Respiratory Therapy Consultant		2,039	10a-3	42
43	Speech Therapy Consultant	F	1,202	10a-3	43
44	Activity Consultant	E	832	11-3	44
45	Social Service Consultant	E	2,563	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 52,929		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		N/A	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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STEPHANIE BIRCH	ADMINISTRATOR	0.00	$ 73,060
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 73,060

B. Administrative - Other

Description		Amount
WEISS MGMT. GROUP,INC	MANAGEMENT FEES	$ 250,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 250,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		589,295
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 589,295

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,915
Unemployment Compensation Insurance	90,042
FICA Taxes	240,801
Employee Health Insurance	70,785
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	19,940
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)	$ 535,483

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	967
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Patient Background Checks 795	7,951
TRUST/FRANCHISE/CONTRIB/ETC	4,781
MARKETING/ADV/PROMO	16,081
LICENSES/DUES/SUBSCRIPTIONS	10,001
MGMT CO ALLOC	4,545
TRUST/FRANCHISE/CONTRIB/ETC	(4,781)
Less: Public Relations Expense	(0)
Non-allowable advertising	(16,081)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,444

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-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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							N/A						
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ATRIUM HC & REHAB CTR-CAHOKIA # 0048645 Report Period Beginning: 01/01/2013 Ending: 12/31/2013

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 $ 13,327**

(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?

(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. $ **4,561** 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 for Schedule VII)? YES **X** NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
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 Department during this cost report period. $ **307,088**
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. $ **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 for 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 other 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.