

		FOR BHF USE					

LL1

**2008**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**  
**FINANCIAL AND STATISTICAL REPORT (COST REPORT)**  
**FOR LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2008)**

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.

<p><b>I. IDPH License ID Number:</b> <u>0048645</u></p> <p><b>Facility Name:</b> <u>ATRIUM HEALTH CARE &amp; REHAB CENTER-CAHOKIA</u></p> <p><b>Address:</b> <u>3354 JEROME LANE</u> <u>CAHOKIA</u> <u>62206</u>          Number City Zip Code</p> <p><b>County:</b> <u>ST. CLAIR</u></p> <p><b>Telephone Number:</b> <u>( 618 ) 337-9400</u> <b>Fax #</b> <u>( 618 ) 332-1811</u></p> <p><b>HFS ID Number:</b> <u>371395559001</u></p> <p><b>Date of Initial License for Current Owners:</b> <u>05/01/00</u></p> <p><b>Type of Ownership:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td><b>IRS Exemption Code</b> _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p><b>In the event there are further questions about this report, please contact:</b>  <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u>  <b>Email Address:</b> _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	<b>IRS Exemption Code</b> _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p><b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b></p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2008</u> to <u>12/31/2008</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 20%;"><b>Officer or Administrator of Provider</b></td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>MARTIN WEISS</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>MEMBER</u></td> </tr> <tr> <td rowspan="4"><b>Paid Preparer</b></td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name &amp; Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td>(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u></td> </tr> </table> <p><b>MAIL TO: BUREAU OF HEALTH FINANCE</b>  <b>ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES</b>  <b>201 S. Grand Avenue East</b>  <b>Springfield, IL 62763-0001</b> Phone # <b>( 217 ) 782-1630</b></p>	<b>Officer or Administrator of Provider</b>	(Signed) _____	(Type or Print Name) <u>MARTIN WEISS</u> (Date) _____		(Title) <u>MEMBER</u>	<b>Paid Preparer</b>	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>	(Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>
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Facility Name & ID Number ATRIUM HEALTH CARE & REHAB CENTER-CAHOKIA

# 0048645 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,934	1
2		Skilled Pediatric (SNF/PED)			2
3	81	Intermediate (ICF)	81	29,646	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,580	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF		744	4,536	5,280	8
9	SNF/PED					9
10	ICF	38,017			38,017	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	38,017	744	4,536	43,297	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.00%

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

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

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

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

K. Was the facility certified for Medicare during the reporting year?  
YES  NO  If YES, enter number of beds certified 20 and days of care provided 4,536

Medicare Intermediary MUTUAL OF OMANA

IV. ACCOUNTING BASIS

ACCRAUAL  MODIFIED CASH\*  CASH\*

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

Tax Year: 12/31/2008 Fiscal Year: 12/31/2008

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

Facility Name & ID Number ATRIUM HEALTH CARE & REHAB CEN1 # 0048645 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	148,747	22,970	13,001	184,718		184,718		184,718		1
2	Food Purchase		216,123		216,123		216,123	(48)	216,075		2
3	Housekeeping	161,733	19,129		180,862		180,862		180,862		3
4	Laundry	68,395	20,511	1,657	90,563		90,563		90,563		4
5	Heat and Other Utilities			116,216	116,216		116,216		116,216		5
6	Maintenance	65,542	33,754	9,314	108,610		108,610		108,610		6
7	Other (specify):*			17,572	17,572		17,572		17,572		7
8	<b>TOTAL General Services</b>	444,417	312,487	157,760	914,664		914,664	(48)	914,616		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,436,923	138,683	32,444	1,608,050		1,608,050	(25,000)	1,583,050		10
10a	Therapy	51,925		1,295	53,220		53,220		53,220		10a
11	Activities	86,654	3,605	852	91,111		91,111		91,111		11
12	Social Services	139,696		2,647	142,343		142,343		142,343		12
13	CNA Training										13
14	Program Transportation			335	335		335		335		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,715,198	142,288	43,573	1,901,059		1,901,059	(25,000)	1,876,059		16
	<b>C. General Administration</b>										
17	Administrative	71,287		220,000	291,287		291,287	184,271	475,558		17
18	Directors Fees										18
19	Professional Services			158,020	158,020		158,020	(121,230)	36,790		19
20	Dues, Fees, Subscriptions & Promotions			34,740	34,740		34,740	(19,397)	15,343		20
21	Clerical & General Office Expenses	104,252	20,893	35,305	160,450		160,450	(37,807)	122,643		21
22	Employee Benefits & Payroll Taxes			300,804	300,804		300,804		300,804		22
23	Inservice Training & Education							462	462		23
24	Travel and Seminar			5,116	5,116		5,116	242	5,358		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			34,202	34,202		34,202	485	34,687		26
27	Other (specify):*							29,210	29,210		27
28	<b>TOTAL General Administration</b>	175,539	20,893	788,187	984,619		984,619	36,236	1,020,855		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,335,154	475,668	989,520	3,800,342		3,800,342	11,188	3,811,530		29

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

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

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	12,364
	REPAIRS & MAINTENANCE	637
		0
		13,001
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	1,657
		0
		1,657
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	10,370
	ELECTRICITY	76,220
	WATER	28,483
	CABLE TV - LOBBY	1,143
		0
		116,216
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	3,999
	PAINTING & DECORATING	0
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	0
	FIRE SERVICE	5,315
		0
		0
		0
		0
		9,314
7	<b>OTHER</b>	
	SCAVENGER & EXTERMINATING SERVICE	17,572
	SECURITY SERVICE	
		0
		0
		17,572
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	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	2,073
	PHARMACY CONSULTANT XVIII B 39-2	5,371
	UTILIZATION REVIEW FEES XVIII B ___-2	0
	PHYSICIANS XVIII B ___-2	0
	PSYCHIATRIC XVIII B ___-2	0
	RN CONSULTANT XVIII B 38-2	25,000
		0
		0
		32,444
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B ___-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	633
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	482
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	180
		1,295
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	852
		0
		852
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	2,647
	SOCIAL WORKER XVIII B 45-2	0
		0
		2,647
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	335
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	220,000
	<b>DIRECTORS FEES</b>	
18	DIRECTORS FEES	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	5,949
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	27,071
	BOOKKEEPING/ADMINISTRATIVE SERVICES	125,000
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	14,155
	EMPLOYEE WANT ADS XIX F	4,577
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	4,265
	LICENSES & PERMITS XIX F	1,261
	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	5,242
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	2,100
	PATIENT BACKGROUND CHECKS XIX F	3,140
		34,740
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	1,313
	EQUIPMENT REPAIR & MAINTENANCE	18,837
	OUTSIDE CLERICAL SERVICES	
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	12,471
	MESSENGER SERVICE	2,684
		0
		35,305

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	176,452
	UNEMPLOYMENT COMPENSATION XIX D	42,051
	WORKERS COMPENSATION INSURANC XIX D	58,052
	HOSPITALIZATION INSURANCE XIX D	20,005
	EMPLOYEE BENEFITS - OTHER XIX D	4,244
	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
		300,804
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	
	EDUCATION & SEMINARS	0
		0
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	1,133
	TRAVEL XIX G	3,983
		5,116
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	0
		0
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	34,202
		34,202
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER

989,520

**ATRIUM HEALTH CARE & REHAB CENTER-CAHOKIA  
SCHEDULES  
12/31/2008**

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

TOTAL FOOD PURCHASE	216,123
LESS SALES TAX	<u>(48)</u>
NET FOOD	216,075

TOTAL PATIENT CENSUS	43,297
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	129,891

ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	<u>366</u>
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	129,891
ADD EMPLOYEE MEALS	<u>0</u>
TOTAL MEALS/YEAR	129,891

NET FOOD	216,075
DIVIDE TOTAL MEALS/YEAR	<u>129,891</u>

COST PER MEAL	1.66
TIME EMPLOYEE MEALS	<u>0</u>
EMPLOYEE MEAL RECLASSIFICATION	<b>0</b>

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## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			51,541	51,541		51,541	(12,415)	39,126			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			33,056	33,056		33,056	(173)	32,883			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			396,779	396,779		396,779	10,061	406,840			34
35	Rent-Equipment & Vehicles			7,322	7,322		7,322	15,808	23,130			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			488,698	488,698		488,698	13,281	501,979			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		430,310	108,998	539,308		539,308		539,308			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,370	71,370		71,370		71,370			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		430,310	180,368	610,678		610,678		610,678			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,335,154	905,978	1,658,586	4,899,718		4,899,718	24,469	4,924,187			45

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

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>BHF USE ONLY</b>	
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	(12,415)	30		9
10	Interest and Other Investment Income	(173)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(48)	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	(5,242)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(1,057)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(14,155)	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 <u>SEE PAGE 5A</u>	(45,221)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (78,311)		\$	30

<b>BHF USE ONLY</b>							
48		49		50		51	

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

		1	2	
		<b>Amount</b>	<b>Reference</b>	
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)	102,780		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 102,780		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ 24,469		37

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

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

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
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	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0048645

Report Period Beginning: 01/01/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	DEFERRED MAINTENANCE	\$ 0	6 1
2	MARKETING SALARIES	(45,221)	21 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	<b>Total</b>	(45,221)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ATRIUM HEALTH CARE & REHAB CENTER-CAHOKIA

# 0048645

Report Period Beginning:

01/01/2008

Ending:

12/31/2008

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(48)	0	0	0	0	0	0	0	0	0	0	(48)	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	<b>TOTAL General Services</b>	<b>(48)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(48)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(25,000)	0	0	0	0	0	0	0	0	0	(25,000)	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	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>(25,000)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(25,000)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(220,000)	0	404,271	0	0	0	0	0	0	0	184,271	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,057)	(125,000)	0	4,827	0	0	0	0	0	0	0	(121,230)	19
20	Fees, Subscriptions & Promotions	(19,397)	0	0	0	0	0	0	0	0	0	0	(19,397)	20
21	Clerical & General Office Expenses	(45,221)	0	0	7,414	0	0	0	0	0	0	0	(37,807)	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	462	0	0	0	0	0	0	0	462	23
24	Travel and Seminar	0	0	0	242	0	0	0	0	0	0	0	242	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	485	0	0	0	0	0	0	0	485	26
27	Other (specify):*	0	0	0	29,210	0	0	0	0	0	0	0	29,210	27
28	<b>TOTAL General Administration</b>	<b>(65,675)</b>	<b>(345,000)</b>	<b>0</b>	<b>446,911</b>	<b>0</b>	<b>36,236</b>	<b>28</b>						
29	<b>TOTAL Operating Expense</b> <b>(sum of lines 8,16 &amp; 28)</b>	<b>(65,723)</b>	<b>(370,000)</b>	<b>0</b>	<b>446,911</b>	<b>0</b>	<b>11,188</b>	<b>29</b>						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ATRIUM HEALTH CARE & REHAB CENTER-CAHOKI # 0048645 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	(12,415)	0	0	0	0	0	0	0	0	0	0	(12,415)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(173)	0	0	0	0	0	0	0	0	0	0	(173)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	10,061	0	0	0	0	0	0	0	10,061	34
35	Rent-Equipment & Vehicles	0	0	0	15,808	0	0	0	0	0	0	0	15,808	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(12,588)</b>	<b>0</b>	<b>0</b>	<b>25,869</b>	<b>0</b>	<b>13,281</b>	<b>37</b>						
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
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	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	<b>(78,311)</b>	<b>(370,000)</b>	<b>0</b>	<b>472,780</b>	<b>0</b>	<b>24,469</b>	<b>45</b>						

**VII. RELATED PARTIES**

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MARTIN J. WEISS	30.00	THE LINCOLN HOME, INC	BELLEVILLE	WEISS MGMT GROUP	SKOKIE	MGMT/CLERICAL
NATAN WEISS	30.00					
DANIEL WEISS	30.00					
GARY A. WEINTRAUB	10.00					

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	10 NURSING CONSULTANT	\$ 25,000	WEISS MANAGEMENT GROUP		\$	\$ (25,000)	1
2	V	17 MANAGEMENT FEES	220,000				(220,000)	2
3	V	19 ADMIN./BKPP. FEES	125,000				(125,000)	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		\$ 370,000			\$	\$ *	(370,000) 14

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

VII. RELATED PARTIES (continued)

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

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

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMINISTRATIVE SALARIES	\$			\$ 404,271	\$	404,271	15
16	V	19 PROFESSIONAL FEES				4,827		4,827	16
17	V	21 OFFICE EXPENSES				7,414		7,414	17
18	V	23 SEMINARS				462		462	18
19	V	24 TRAVEL				242		242	19
20	V	26 INSURANCE				485		485	20
21	V	27 EMPLOYEE BENEFITS				29,210		29,210	21
22	V	34 OFFICE RENT				10,061		10,061	22
23	V	35 EQUIPMENT RENT				15,808		15,808	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 472,780	\$ *	472,780	39

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

Facility Name & ID Number ATRIUM HEALTH CARE & REHAB CEN # 0048645 Report Period Beginning: 01/01/2008 Ending: 12/31/2008

## VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MARTIN WEISS	PRESIDENT	ADMINISTR.	30.00	SEE ATTACHED	20		SALARY	\$ 127,598	17-7	1
2					SCHEDULE						2
3											3
4	DANIEL WEISS	MANAGER	MANAGEMENT	30.00		12		SALARY	153,218	17-7	4
5											5
6	NATAN WEISS	CONTROLLER	BOOKKEPING	30.00		16		SALARY	123,455	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 404,271		13

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

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

Facility Name & ID Number ATRIUM HEALTH CARE & REHAB CENTER-CAHOK # 0048645 Report Period Beginning: 01/01/2008 Ending: 2/31/2008

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization 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	17	ADMINISTRATIVE SALARIES	PATIENT CENSUS	93,914	2	\$ 876,890	\$ 876,890	43,297	\$ 404,271	1
2	19	PROFESSIONAL FEES	PATIENT CENSUS	93,914	2	10,469	43,297		4,827	2
3	21	OFFICE EXPENSES	PATIENT CENSUS	93,914	2	16,081	43,297		7,414	3
4	23	SEMINARS	PATIENT CENSUS	93,914	2	1,002	43,297		462	4
5	24	TRAVEL	PATIENT CENSUS	93,914	2	524	43,297		242	5
6	26	INSURANCE	PATIENT CENSUS	93,914	2	1,053	43,297		485	6
7	27	EMPLOYEE BENEFITS	PATIENT CENSUS	93,914	2	63,358	43,297		29,210	7
8	34	OFFICE RENT	PATIENT CENSUS	93,914	2	21,822	43,297		10,061	8
9	35	EQUIPMENT RENT	PATIENT CENSUS	93,914	2	34,289	43,297		15,808	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,025,488	\$ 876,890		\$ 472,780	25

**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**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
											YES	NO				Original	Balance			
<b>A. Directly Facility Related</b>																				
<b>Long-Term</b>																				
1																				
2																				
3																				
4																				
5																				
<b>Working Capital</b>																				
6	BANK FINANCIAL	X	LINE OF CREDIT	DEMAND	10/01/06	1,200,000	316,995		PRIME+	14,174										
7	BANK FINANCIAL	X	WORKING CAPITAL	DEMAND	05/14/07	300,000	237,442		PRIME+	16,173										
8	US BANK	X	AUTO LOAN	\$749.80	02/08	37,400	31,862	02/13	7.5000	2,709										
9	TOTAL Facility Related			\$749.80		\$ 1,537,400	\$ 586,299			\$ 33,056										
<b>B. Non-Facility Related*</b>																				
10																				
11																				
12																				
13																				
14	TOTAL Non-Facility Related					\$	\$			\$										
15	TOTALS (line 9+line14)					\$ 1,537,400	\$ 586,299			\$ 33,056										

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

\* 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.)

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

**B. Real Estate Taxes**

**Important**, please see the next worksheet, "RE\_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2007 report.

\$ **54,288** 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.)

\$ **54,288** 2

3. Under or (over) accrual (line 2 minus line 1).

\$ **54,288** 3

4. Real Estate Tax accrual used for 2008 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.

\$ **54,288** 7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2003	<b>39,419</b>	8
	2004	<b>43,239</b>	9
	2005	<b>47,880</b>	10
	2006	<b>49,290</b>	11
	2007	<b>54,288</b>	12

**FOR BHF USE ONLY**

13	FROM R. E. TAX STATEMENT FOR 2007	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**THE PAYMENT ON LINE 2 APPLIES TO THE 2007 TAX BILL.**

**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.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates **RE:** 2007 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2007 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2007.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2007 real estate tax bill to Healthcare and Family Services, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2008 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2007 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME ATRIUM HEALTH CARE & REHAB CENTER-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 2007 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 2007.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>06-12.0-206-016</u>	<u>NURSING HOME</u>	\$ <u>54,287.66</u>	\$ <u>54,287.66</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>54,287.66</u>	\$ <u>54,287.66</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES       X       NO

If YES, attach an explanation & 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 2007 tax bills which were listed in Section A to this statement. Be sure to use the 2007 tax bill which is normally paid during 2008.

**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.

**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.  (c) Rent from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?  (a) Own the Equipment  (b) Rent equipment from a Related Organization.  (c) Rent equipment from Completely Unrelated Organization.  
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.)  
List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

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

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number **ATRIUM HEALTH CARE & REHAB CENTER-CAHOKIA**# **0048645**

Report Period Beginning:

01/01/2008 Ending: 12/31/2008

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4				\$	\$		\$	\$	\$	4
5										5
6										6
7										7
8										8
	<b>Improvement Type**</b>									
9	INSTALL A NEW DURO-LAST ROOFING SYSTEM		2006	30,000	1,091	27.5	1,091		2,382	9
10	AIR CONDITIONS		2006	947	223	5	223		649	10
11	INSTALLATION OF EXHAUST SYSTEM		2007	3,340	121	27.5	121		237	11
12	AIR CONDITIONS		2007	11,065	3,541	5	3,541		5,754	12
13	INSTALLATION OF ROOFTOP UNIT		2007	4,140	151	27.5	151		245	13
14	CALLCARE STATION REPLACEMENT		2007	3,122	114	27.5	114		176	14
15	EXCAVATE AND REPAIR DRIVEWAY, RENOVATION PATIO		2007	6,870	458	15	458		496	15
16	INSTALLATION OF DOORS-FRONT ENTRANCE, VESTIBULE		2007	11,640	423	27.5	423		476	16
17	PAINTING		2007	7,587	2,428	5	2,428		3,945	17
18	WINDOW TREATMENTS AND CUBICLE CURTAINS		2007	14,027	4,489	5	4,489		7,294	18
19	BUILDING RENOVATION AND REMODELING: A,B,C,D-WINGS CORRIDOR, RESIDENT ROOMS, THERAPY		2007	228,253	8,300	27.5	8,300		8,646	19
20										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	990	27.5	990		990	24
25	SHOWER-VARIOUS DIFFERENT AREAS		2008	16,266	419	27.5	419		419	25
26	INSTALL A NEW DURO-LAST ROOFING SYSTEM		2008	26,400	520	27.5	520		520	26
27	INSTALL NEW OFFICE, SIDEWALK TO THE OFFICE		2008	29,175	575	27.5	575		575	27
28	INSTALLATION OF ALARM SYSTEM		2008	42,875	715	27.5	715		715	28
29	INSTALLATION OF DOORS-OXYGEN ROOM, COURTYARD		2008	6,147	121	27.5	121		121	29
30	AIR CONDITIONS, WATER HEATER		2008	5,513	1,103	5	1,103		1,103	30
31	REPLACE EXISTING SPRINKLER PIPING		2008	9,498	43	27.5	43		43	31
32	SEALING PARKING LOT		2008	2,500	56	15	56		56	32
33										33
34										34
35										35
36										36

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

See Page 12A, Line 70 for total

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

**XI. OWNERSHIP COSTS (continued)**

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)	\$ 493,747	\$ 25,881		\$ 25,881	\$	\$ 34,842	70

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 39,361	\$ 12,596	\$ 4,301	\$ (8,295)	8-10	\$ 6,451	71
72	Current Year Purchases	27,921	5,584	1,464	(4,120)	8-10	1,464	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 67,282	\$ 18,180	\$ 5,765	\$ (12,415)		\$ 7,915	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2008 FORD WGN	2008	\$ 37,400	\$ 7,480	\$ 7,480	\$	5	\$ 7,480	76
77										77
78										78
79										79
80	TOTALS			\$ 37,400	\$ 7,480	\$ 7,480	\$		\$ 7,480	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)	\$ 598,429	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 51,541	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 39,126	83**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (12,415)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 50,237	85

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

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

G. Construction-in-Progress

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

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

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

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: 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.  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:	<u>130</u>	<u>09/01/06</u>	\$ <u>396,779</u>	<u>15</u>		3
4	Additions						4
5							5
6							6
7	<b>TOTAL</b>	<b>130</b>		\$ <b>396,779</b>			<b>7</b>

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

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

9. Option to Buy:  YES  NO Terms: \_\_\_\_\_\*

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

15. Is Movable equipment rental included in building rental?

YES  NO

16. Rental Amount for movable equipment: \$ 7,322 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			<u>N/A</u>		18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	<b>21</b>

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. 09/01/2009 \$ 342,000

13. 09/01/2010 \$ 367,500

14. 09/01/2011 \$ 393,225

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

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

**XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)**

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p><b>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</b></p>		

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

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

**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**

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

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

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

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 174,584	\$		\$ 174,584	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			57,850			57,850	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			197,876			197,876	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				89,760		89,760	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): <u>MEDICAL SUPPLIES</u>	39-2					7,735		7,735	12
13	Other (specify): <u>RADIOLOGY, LAB</u>	39-2					11,503		11,503	13
14	TOTAL			\$		\$ 430,310	\$ 108,998		\$ 539,308	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **ATRIUM HEALTH CARE & REHAB CENTER-CAHOKI# 0048645** Report Period Beginning: **01/01/2008** Ending: **12/31/2008**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **12/31/2008** (last day of reporting year)

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

		1	2	
		Operating	After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (80,981)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,360,242		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	99,470		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 1,378,731	\$	10
	<b>B. Long-Term Assets</b>			
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	493,747		15
16	Equipment, at Historical Cost	104,683		16
17	Accumulated Depreciation (book methods)	(68,374)		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	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 530,056	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,908,787	\$	25

		1	2	
		Operating	After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 195,965	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,315		28
29	Short-Term Notes Payable	598,047		29
30	Accrued Salaries Payable	129,074		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,958		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
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 933,359	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 933,359	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 975,428	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,908,787	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>502,050</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>PRIOR YEAR ADJUSTMENTS</b>	<b>(5,809)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>496,241</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>479,187</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>479,187</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>975,428</b>	<b>24</b> *

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

**XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.**

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 5,151,429	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,151,429	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	227,303	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 227,303	8
	<b>C. Other Operating Revenue</b>		
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	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	173	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 173	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 5,378,905	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	914,664	31
32	Health Care	1,901,059	32
33	General Administration	984,619	33
	<b>B. Capital Expense</b>		
34	Ownership	488,698	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	539,308	35
36	Provider Participation Fee	71,370	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,899,718	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	479,187	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 479,187	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 HEALTH CARE & REHAB CENTER-CAHOKL**

# **0048645**

Report Period Beginning: **01/01/2008**

Ending:

**12/31/2008**

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,904	2,080	\$ 80,904	\$ 38.90	1
2	Assistant Director of Nursing	1,850	1,882	54,334	28.87	2
3	Registered Nurses	3,125	3,157	76,651	24.28	3
4	Licensed Practical Nurses	25,037	25,893	503,907	19.46	4
5	CNAs & Orderlies	64,641	67,008	609,952	9.10	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,439	5,710	51,925	9.09	8
9	Activity Director					9
10	Activity Assistants	8,695	9,003	86,654	9.63	10
11	Social Service Workers	12,241	12,949	139,696	10.79	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	17,914	18,226	148,747	8.16	15
16	Dishwashers					16
17	Maintenance Workers	4,966	5,230	65,542	12.53	17
18	Housekeepers	19,424	19,998	161,733	8.09	18
19	Laundry	8,077	8,326	68,395	8.21	19
20	Administrator	1,936	2,080	71,287	34.27	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,683	8,020	104,252	13.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,846	2,046	22,686	11.09	31
32	Other Health Care(specify)	3,912	4,136	88,489	21.39	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	188,690	195,744	\$ 2,335,154 *	\$ 11.93	34

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

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 12,364	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	2,073	10-3	37
38	Nurse Consultant	T	25,000	10-3	38
39	Pharmacist Consultant	H	5,371	10-3	39
40	Physical Therapy Consultant	L	633	10a-3	40
41	Occupational Therapy Consultant	Y	482	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	180	10a-3	43
44	Activity Consultant	E	852	11-3	44
45	Social Service Consultant	E	2,647	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 55,602		49

**C. CONTRACT NURSES**

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	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

**XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount		Description		Amount	
<u>KENYA WASHINGTON</u>	<u>ADMINISTRATOR</u>	<u>0</u>	<u>\$ 71,287</u>	<u>Workers' Compensation Insurance</u>		<u>\$ 58,052</u>		<u>IDPH License Fee</u>		<u>\$ 861</u>	
				<u>Unemployment Compensation Insurance</u>		<u>42,051</u>		<u>Advertising: Employee Recruitment</u>		<u>4,577</u>	
				<u>FICA Taxes</u>		<u>176,452</u>		<u>Health Care Worker Background Check</u>		<u>2,100</u>	
				<u>Employee Health Insurance</u>		<u>20,005</u>		<u>(Indicate # of checks performed <u>210</u>)</u>			
				<u>Employee Meals</u>		<u>0</u>		<u>Patient Background Checks</u>	<u>314</u>	<u>3,140</u>	
				<u>Illinois Municipal Retirement Fund (IMRF)*</u>				<u>TRUST/FRANCHISE/CONTRIB/ETC</u>		<u>5,242</u>	
				<u>EMPLOYEE BENEFITS - OTHER</u>		<u>4,244</u>		<u>MARKETING/ADV/PROMO</u>		<u>14,155</u>	
				<u>EMPLOYEE PHYSICAL EXAMS</u>		<u>0</u>		<u>LICENSES/DUES/SUBSCRIPTIONS</u>		<u>4,665</u>	
				<u>PENSION/PROFIT SHARING PLANS</u>		<u>0</u>					
				<u>CHICAGO HEAD TAX</u>		<u>0</u>		<u>TRUST/FRANCHISE/CONTRIB/ETC</u>		<u>(5,242)</u>	
				<u>INSURANCE - EXECUTIVE LIFE</u>		<u>0</u>		<u>Less: Public Relations Expense</u>		<u>( 0 )</u>	
				<u>INSURANCE - EXECUTIVE LIFE VI 21</u>		<u>0</u>		<u>Non-allowable advertising</u>		<u>(14,155)</u>	
								<u>Yellow page advertising</u>		<u>( 0 )</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 1)</b>			<b>\$ 71,287</b>	<b>TOTAL (agree to Schedule V, line 22, col.8)</b>		<b>\$ 300,804</b>		<b>TOTAL (agree to Sch. V, line 20, col. 8)</b>		<b>\$ 15,343</b>	
<b>(List each licensed administrator separately.)</b>											
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Description			Amount	Description	Line #	Amount		Description		Amount	
<u>WEISS MANAGEMENT GROUP,INC MANAGEMENT FEES</u>			<u>\$ 220,000</u>					<u>Out-of-State Travel</u>		<u>\$</u>	
								<u>In-State Travel</u>		<u>3,983</u>	
								<u>MGMT CO ALLOC</u>		<u>242</u>	
<b>TOTAL (agree to Schedule V, line 17, col. 3)</b>			<b>\$ 220,000</b>					<u>Seminar Expense</u>		<u>1,133</u>	
<b>(Attach a copy of any management service agreement)</b>											
C. Professional Services				TOTAL				Entertainment Expense			
Vendor/Payee	Type		Amount								
<u>ALPHA DATA SERVICES</u>	<u>DATA PROCESSING</u>		<u>\$ 5,949</u>	<b>TOTAL</b>		<b>\$</b>		<u>(agree to Sch. V, line 24, col. 8)</u>		<u>( )</u>	
<u>KRUPNICK,BOKOR,KAGDA</u>	<u>ACCOUNTING FEES</u>		<u>3,250</u>					<b>TOTAL</b>		<b>\$ 5,358</b>	
<u>PERSONNEL PLANERS</u>	<u>UC CONSULTANT</u>		<u>2,551</u>								
<u>SHARON HAUGH</u>	<u>MEDICARE CONSULTANT</u>		<u>3,000</u>								
<u>GARY A. WEINTRAUB</u>	<u>LEGAL FEES</u>		<u>13,770</u>								
<u>RICHARD PEELO</u>	<u>MEDICARE CONSULTANT</u>		<u>4,500</u>								
<u>WEISS MGMT GROUP</u>	<u>BOOKKEEPING/ADMIN</u>		<u>125,000</u>								
<b>TOTAL (agree to Schedule V, line 19, column 3)</b>			<b>\$ 158,020</b>								
<b>(If total legal fees exceed \$5,000, attach copy of invoices.)</b>											

\* Attach copy of IMRF notifications

\*\*See instructions.



Facility Name & ID Number ATRIUM HEALTH CARE & REHAB CENTER-CAHOKIA# 0048645Report Period Beginning: 01/01/2008Ending: 12/31/2008**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 \$4,190
- (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. \$ 1,910 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. \$ 71,370  
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: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees