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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0035642

Facility Name: TRANSITIONS NURSING AND REHAB CENTER

Address: 1000 DIXON AVENUE (Number) ROCK FALLS (City) 61071 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 625-8510 **Fax #** (815) 625-8443

HFS ID Number:

Date of Initial License for Current Owners: 07/01/89

Type of Ownership:

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

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2010 to 12/31/2010 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) ROBERT HEDGES
(Title) PRESIDENT

Paid Preparer

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

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	55	Skilled (SNF)	55	20,075	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	55	TOTALS	55	20,075	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	1,735	32	2,063	3,830	8
9	SNF/PED					9
10	ICF	10,420	532		10,952	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	12,155	564	2,063	14,782	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.63%

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 07/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 07/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 55 and days of care provided 2,063

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2010 Fiscal Year: 12/31/2010

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CE # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	107,530	5,104	8,836	121,470		121,470		121,470			1
2	Food Purchase		76,601		76,601	(5,804)	70,797	(94)	70,703			2
3	Housekeeping	53,732	11,965		65,697		65,697		65,697			3
4	Laundry	35,277	6,787	1,152	43,216		43,216		43,216			4
5	Heat and Other Utilities			73,534	73,534		73,534		73,534			5
6	Maintenance	20,743	8,701	18,554	47,998		47,998	2,736	50,734			6
7	Other (specify):*			6,498	6,498		6,498		6,498			7
8	**TOTAL General Services**	217,282	109,158	108,574	435,014	(5,804)	429,210	2,642	431,852			8
	B. Health Care and Programs											
9	Medical Director			24,000	24,000		24,000		24,000			9
10	Nursing and Medical Records	711,185	63,617	9,734	784,536		784,536	(48)	784,488			10
10a	Therapy	28,790	620	325	29,735		29,735		29,735			10a
11	Activities	55,427	1,583		57,010		57,010		57,010			11
12	Social Services	26,691		2,719	29,410		29,410		29,410			12
13	CNA Training											13
14	Program Transportation			662	662		662		662			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	822,093	65,820	37,440	925,353		925,353	(48)	925,305			16
	C. General Administration											
17	Administrative	63,475			63,475		63,475	37,088	100,563			17
18	Directors Fees											18
19	Professional Services			35,928	35,928		35,928		35,928			19
20	Dues, Fees, Subscriptions & Promotions			17,069	17,069		17,069	(9,375)	7,694			20
21	Clerical & General Office Expenses	54,188	6,465	30,556	91,209		91,209	10,514	101,723			21
22	Employee Benefits & Payroll Taxes			140,365	140,365	5,804	146,169		146,169			22
23	Inservice Training & Education			5,983	5,983		5,983		5,983			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			15,423	15,423		15,423	(5,171)	10,252			25
26	Insurance-Prop.Liab.Malpractice			31,789	31,789		31,789		31,789			26
27	Other (specify):*			21,692	21,692		21,692	(17,309)	4,383			27
28	**TOTAL General Administration**	117,663	6,465	298,805	422,933	5,804	428,737	15,747	444,484			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,157,038	181,443	444,819	1,783,300		1,783,300	18,341	1,801,641			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#: TRANSITIONS NURSING AND REHAB CENTEF #0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,836	
	REPAIRS & MAINTENANCE		0	
			0	8,836
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,152	
			0	1,152
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		15,471	
	ELECTRICITY		26,850	
	WATER		26,025	
	CABLE TV - LOBBY		5,188	
			0	73,534
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,827	
	PAINTING & DECORATING		445	
	BUILDING REPAIRS		8,914	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		1,699	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,046	
	FIRE SERVICE		3,623	
			0	
			0	
			0	
			0	18,554
7	**OTHER**			
	SCAVENGER		6,498	
	SECURITY SERVICE		0	
			0	
			0	6,498
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	24,000	24,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		6,851	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,530	
	PHARMACY CONSULTANT	XVIII B 39-2	1,353	
	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	9,734
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	325	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	
				325
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS			
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		269	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,450	
			0	2,719
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER #0035642 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		662	662
			0	
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
	DIRECTORS FEES			
18	DIRECTORS FEES		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	7,751	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	28,177	
			0	35,928
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,977	
	EMPLOYEE WANT ADS	XIX F	1,130	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	2,986	
	LICENSES & PERMITS	XIX F	1,788	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,103	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,295	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,135	
	PATIENT BACKGROUND CHECKS	XIX F	655	
				17,069
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		10,810	
	EQUIPMENT REPAIR & MAINTENANCE		1,548	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		12,000	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		6,198	
	MESSENGER SERVICE		0	
			0	30,556

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	88,474	
	UNEMPLOYMENT COMPENSATION	XIX D	13,330	
	WORKERS COMPENSATION INSURANC	XIX D	30,191	
	HOSPITALIZATION INSURANCE	XIX D	3,970	
	EMPLOYEE BENEFITS - OTHER	XIX D	4,400	
	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	140,365
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,983	
				5,983
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
				0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		15,423	
				15,423
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		31,789	
				31,789
27	**OTHER**			
	BAD DEBTS	VI 24	21,692	
				21,692

GRAND TOTAL COLUMN 3 OTHER **444,819**

TRANSITIONS NURSING AND REHAB CENTER
SCHEDULES
12/31/2010

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

TOTAL FOOD PURCHASE	76,601
LESS SALES TAX	(94)
NET FOOD	76,507
TOTAL PATIENT CENSUS	14,782
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	44,346
ADD # EMPLOYEE MEALS/DAY	10
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	3,650
PATIENT MEALS	44,346
ADD EMPLOYEE MEALS	3,650
TOTAL MEALS/YEAR	47,996
NET FOOD	76,507
DIVIDE TOTAL MEALS/YEAR	47,996
COST PER MEAL	1.59
TIME EMPLOYEE MEALS	3,650
EMPLOYEE MEAL RECLASSIFICATION	**5,804**
	=========

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER #0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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			12,457	12,457		12,457	21,807	34,264			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			17,990	17,990		17,990	91,995	109,985			32
33	Real Estate Taxes			10,885	10,885		10,885	544	11,429			33
34	Rent-Facility & Grounds			138,188	138,188		138,188	(138,188)				34
35	Rent-Equipment & Vehicles			29,636	29,636		29,636		29,636			35
36	Other (specify):*											36
37	TOTAL Ownership			209,156	209,156		209,156	(23,842)	185,314			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		115,887	234,922	350,809		350,809		350,809			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,113	30,113		30,113		30,113			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		115,887	265,035	380,922		380,922		380,922			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,157,038	297,330	919,010	2,373,378		2,373,378	(5,501)	2,367,877			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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	3,449	30		9
10	Interest and Other Investment Income	(49)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(94)	2		13
14	Non-Care Related Interest	(380)	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	(1,295)	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	(21,692)	27		24
25	Fund Raising, Advertising and Promotional	(6,977)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(1,103)	20		28
29	Other-Attach Schedule	(21,769)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,910)		$	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)	44,409		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 44,409		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (5,501)		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.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

TRANSITIONS NURSING AND REHAB CENTER

ID# 0035642

Report Period Beginning: 01/01/2010

Ending: 12/31/2010

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$	6	1
2	HEALTHCARE HORIZONS	(5,500)	10	2
3	MARKETING SALARY	(11,098)	21	3
4	STAFF TRANSPORTATION - MARKETING	(5,171)	25	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**	(21,769)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER **#** 0035642 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(94)	0	0	0	0	0	0	0	0	0	0	(94)	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	2,736	0	0	0	0	0	0	0	0	0	2,736	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(94)	2,736	0	0	0	0	0	0	0	0	0	2,642	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	(5,500)	5,452	0	0	0	0	0	0	0	0	0	(48)	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**	(5,500)	5,452	0	0	0	0	0	0	0	0	0	(48)	16
	C. General Administration													
17	Administrative	0	37,088	0	0	0	0	0	0	0	0	0	37,088	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,375)	0	0	0	0	0	0	0	0	0	0	(9,375)	20
21	Clerical & General Office Expenses	(11,098)	21,612	0	0	0	0	0	0	0	0	0	10,514	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	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(5,171)	0	0	0	0	0	0	0	0	0	0	(5,171)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(21,692)	4,383	0	0	0	0	0	0	0	0	0	(17,309)	27
28	**TOTAL General Administration**	(47,336)	63,083	0	0	0	0	0	0	0	0	0	15,747	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,930)	71,271	0	0	0	0	0	0	0	0	0	18,341	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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	3,449	0	458	17,900	0	0	0	0	0	0	0	21,807	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(429)	0	1,106	91,318	0	0	0	0	0	0	0	91,995	32
33	Real Estate Taxes	0	0	544	0	0	0	0	0	0	0	0	544	33
34	Rent-Facility & Grounds	0	0	0	(138,188)	0	0	0	0	0	0	0	(138,188)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	3,020	0	2,108	(28,970)	0	0	0	0	0	0	0	(23,842)	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)	(49,910)	71,271	2,108	(28,970)	0	0	0	0	0	0	0	(5,501)	45

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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
				HI CARE	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	50			MANAGEMENT		
		SEE ATTACHED SCHEDULE				
ROBERT HEDGES	50			H.I. PROPERTIES	SPRINGFIELD	REAL ESTATE
				HEALTHCARE	SPRINGFIELD	NURSE
				HORIZONS		CONSULTANT

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		MANAGEMENT FEES	$	HI CARE MANAGEMENT		$	$	1
2	V	21	HOME OFFICE EXPENSE		" " "				2
3	V	6	MAINTENANCE		" " "		2,736	2,736	3
4	V	10	NURSING		" " "		5,452	5,452	4
5	V	17	ADMINISTRATIVE		" " "		37,088	37,088	5
6	V	21	OFFICE EXPENSE		" " "		21,612	21,612	6
7	V	27	PAYROLL TAXES & GRP INS		" " "		4,383	4,383	7
8	V				" " "				8
9	V				" " "				9
10	V				" " "				10
11	V				" " "				11
12	V				" " "				12
13	V				" " "				13
14	Total			$			$ 71,271	$ * 71,271	14

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	30	DEPRECIATION	$	H & I PROPERTIES (HOME OFFICE)		$ 458	$ 458	15
16	V	32	INTEREST		" " " "		1,106	1,106	16
17	V	33	REAL ESTATE TAXES		" " " "		544	544	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 2,108	$ * 2,108	39

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	34	RENT	$ 138,188	H & I PROPERTIES (FACILITY)		$	$ (138,188)	15
16	V	30	DEPRECIATION		" " "		17,900	17,900	16
17	V	32	INTEREST		" " "		91,318	91,318	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 138,188			$ 109,218	$ * (28,970)	39

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB C # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.					SALARY	$ 13,865	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.		SEE			SALARY	13,299	17-7	4
5					ATTACHED						5
6					SCHEDULE						6
7	MARTHA IRVINE	BOOKKEEPING						SALARY	1,036	21-7	7
8											8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	5,979	17-7	10
11											11
12											12
13								TOTAL	$ 34,179		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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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: HI CARE MANAGEMENT
Street Address: 1625 SOUTH 6TH STREET
City / State / Zip Code: SPRINGFIELD, IL. 62703
Phone Number: (217) 528-0044
Fax Number: (217) 528-0412

	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	6	MAINTENANCE	PER RESIDENT DAY	206,077	8	$ 38,149	$ 38,149	14,782	$ 2,736	1
2	10	NURSING	PER RESIDENT DAY	206,077	8	76,000	76,000	14,782	5,452	2
3	17	OFFICER SALARY- IRVINE	PER RESIDENT DAY	206,077	8	185,400	185,400	14,782	13,299	3
4	17	OFFICER SALARY- HEDGES	PER RESIDENT DAY	206,077	8	193,296	193,296	14,782	13,865	4
5	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	206,077	8	55,000	55,000	14,782	3,945	5
6	17	SPECIAL PROJ MNGR- HEDGE	PER RESIDENT DAY	206,077	8	83,349	83,349	14,782	5,979	6
7	21	OFFICE EXPENSE	PER RESIDENT DAY	206,077	8	301,295	301,295	14,782	21,612	7
8	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	206,077	8	61,099		14,782	4,383	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 993,588	$ 932,489		$ 71,271	25

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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: H & I PROPERTIES-HOME OFFICE
Street Address: 1625 S SIXTH STREET
City / State / Zip Code: SPRINGFIELD IL 62703
Phone Number: (217)528-0044
Fax Number: (217)528-0412

	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	30	DEPRECIATION	PER LICENSED BED	810	8	$ 6,741	$	55	$ 458	1
2	32	INTEREST	PER LICENSED BED	810	8	16,292		55	1,106	2
3	33	REAL ESTATE	PER LICENSED BED	810	8	8,006		55	544	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 31,039	$		$ 2,108	25

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 2/31/2010

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: H & I PROPERTIES - FACILITY
Street Address: 1625 S SIXTH STREET
City / State / Zip Code: SPRINGFIELD IL 62703
Phone Number: (217)528-0044
Fax Number: (217)528-0412

	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	30	DEPRECIATION	DIRECT	1	1	$ 17,900	$	1	$ 17,900	1
2	32	INTEREST	DIRECT	1	1	91,318		1	91,318	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 109,218	$		$ 109,218	25

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CE # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	COLE TAYLOR (HI PROP)		X	MORTGAGE (FACILITY)	$10,935.00	8/03/05	$ 1,410,500	$	8/01/10	0.0700	$ 91,318	1
2	US BANK (HI PROP)		X	MORTGAGE (OFFICE)		6/29/05		16,894	6/29/12	0.0635	1,106	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR BANK		X	LINE OF CREDIT	INTEREST	REVOLE		397,220	REVOL	PRIME+	17,610	6
7												7
8												8
9	TOTAL Facility Related				$10,935.00		$ 1,410,500	$ 414,114			$ 110,034	9
	B. Non-Facility Related*											
10												10
11											380	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 380	14
15	TOTALS (line 9+line14)						$ 1,410,500	$ 414,114			$ 110,414	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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 **Report Period Beginning:** 01/01/2010 **Ending:** 12/31/2010

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2009 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 10,642	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.)		$ 10,763	2
3. Under or (over) accrual (line 2 minus line 1).		$ 122	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,763	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.		$ 10,885	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2005	16,077	8
	2006	16,196	9
	2007	15,804	10
	2008	10,642	11
	2009	10,763	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2009 TAX BILL.

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TRANSITIONS NURSING AND REHAB CENTER COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035642

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 2009 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 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-27-401-002	NURSING HOME	$ 10,763.48	$ 10,763.48
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 10,763.48	$ 10,763.48

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 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,780 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories 1

C. Does the Operating Entity? [X] (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? [X] (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).

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	NURSING HOME	67,000	1998	$ 83,295	1
2	OFFICE BUILDING		2005	6,902	2
3	TOTALS	67,000		$ 90,197	3

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	55			1998	$ 698,118	$ 17,900	39	$ 17,900	$	$ 203,632	4
5											5
6	H&I										6
7	Properties										7
8	office bldg			2005	17,877	458	39	458			8
	Improvement Type**										
9	PARKING LOT IMPROVEMENTS			1992	17,677	561	31.5	561		10,373	9
10	CURTAIN TRACKS			1993	5,650	179	31.5	179		3,215	10
11	REWIRING WORK			1996	6,043	155	39	155		2,267	11
12	ROOF			1997	66,564	1,707	39	1,707		22,689	12
13	OUTDOOR FLOODLIGHTS			1997	2,856	73	39	73		952	13
14	HANDRAILS& WALL GUARDS			1999	2,524	65	39	65		750	14
15	STORAGE BARN			1999	2,100	54	39	54		623	15
16	BACKFLOW PREVENTER			2000	1,696	62	27.5	62		653	16
17	ROOF			2000	2,680	97	27.5	97		1,023	17
18	NEW WATER HEATER			2001	3,096	113	27.5	113		1,078	18
19	ALARM SYSTEM			2001	5,013	182	27.5	182		1,737	19
20	OVERBED LIGHT			2001	3,687	134	27.5	134		1,279	20
21	CARPET			2001	1,730		5				21
22	WATER HEATER TANK			2002	1,678	61	27.5	61		521	22
23	ALARM SYSTEM			2002	4,991	182	27.5	182		1,555	23
24	WATER HEATER			2003	2,846	103	27.5	103		777	24
25	WATER HEATER			2004	5,299	193	27.5	193		1,311	25
26	WINDOWS			2005	35,827	1,303	27.5	1,303		6,515	26
27	SMOKE DETECTORS			2005	1,754	64	27.5	64		355	27
28	STEEL FIRE DOOR			2005	1,974	72	27.5	72		399	28
29	FIRE SYSTEM			2005	1,769	64	27.5	64		354	29
30	CARPETING & TILING			2006	13,437	489	27.5	489		2,342	30
31	WATER SOFTENER			2006	3,425	124	27.5	124		595	31
32	GENERATOR			2006	49,050	1,784	27.5	1,784		7,508	32
33	WATER HEATER			2007	5,007	182	27.5	182		645	33
34											34
35											35
36											36

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

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

See Page 12A, Line 70 for total

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	DOORS	2009	$ 3,691	$ 134	27.5	$ 134	$	$ 251	37
38	FLOORING	2009	5,152	824	5	1,030	206	2,060	38
39	FLOORING	2009	2,809	450	5	562	112	1,124	39
40	MOULDINGS FOR DOORWAYS	2010	4,000	42	27.5	42		42	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)		$ 980,020	$ 27,811		$ 28,129	$ 318	$ 276,625	70

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	$ 60,419	$ 2,719	$ 5,718	$ 2,999	10 YRS	$ 43,326	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	47,774					47,774	73
74								74
75	TOTALS	$ 108,193	$ 2,719	$ 5,718	$ 2,999		$ 91,100	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		95 BUICK CENTRY	2000	$ 6,181	$	$	$	3	$ 6,181	76
77		93 FORD WHEEL CHAIR VAN	2008	2,500	285	417	132	3	1,251	77
78										78
79										79
80	TOTALS			$ 8,681	$ 285	$ 417	$ 132		$ 7,432	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)	$ 1,187,091	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,815	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,264	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,449	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 375,157	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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
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:		55		$ 138,188			3
4	Additions							4
5								5
6								6
7	TOTAL		55		$ 138,188 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 29,636 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

	1	2	3	4	5	6	7	8	
	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	$		$ 110,854	$		$ 110,854	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			12,318			12,318	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			111,750			111,750	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				115,887		115,887	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$ 234,922	$ 115,887		$ 350,809	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.

STATE OF ILLINOIS

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2010 (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	$ 364,787	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (25,000))	280,750		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,488		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 680,025	$	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	264,025		15
16	Equipment, at Historical Cost	114,374		16
17	Accumulated Depreciation (book methods)	(191,074)		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)**	$ 187,325	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 867,350	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 370,523	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	397,220		29
30	Accrued Salaries Payable	40,254		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,931		31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,763		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	OTHER LOAN	322,870		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,157,561	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,322,029		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)**	$ 1,322,029	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,479,590	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,612,240)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 867,350	$	48

*(See instructions.)

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,617,005)	1
2	Restatements (describe):		2
3	POST CLOSING	(2,771)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,619,776)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	7,536	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)**	$ 7,536	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,612,240)	24 *

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTEI # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,246,670	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,246,670	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	135,010	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 135,010	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***	49	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 49	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	LOSS ON SALE OF ASSETS	(815)	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (815)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,380,914	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	435,014	31
32	Health Care	925,353	32
33	General Administration	422,933	33
	B. Capital Expense		
34	Ownership	209,156	34
	C. Ancillary Expense		
35	Special Cost Centers	350,809	35
36	Provider Participation Fee	30,113	36
	D. Other Expenses (specify):		
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,373,378	40
41	**Income before Income Taxes (line 30 minus line 40)****	7,536	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 7,536	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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	2,002	2,216	$ 56,137	$ 25.33	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,230	3,737	80,380	21.51	3
4	Licensed Practical Nurses	9,855	10,886	213,748	19.64	4
5	CNAs & Orderlies	31,505	33,748	309,690	9.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,849	2,233	28,790	12.89	8
9	Activity Director	1,784	2,045	25,980	12.70	9
10	Activity Assistants	2,317	3,091	29,447	9.53	10
11	Social Service Workers	1,867	2,229	26,691	11.97	11
12	Dietician					12
13	Food Service Supervisor	2,040	2,148	21,977	10.23	13
14	Head Cook	4,926	5,104	41,823	8.19	14
15	Cook Helpers/Assistants	4,837	5,378	43,730	8.13	15
16	Dishwashers					16
17	Maintenance Workers	1,854	1,990	20,743	10.42	17
18	Housekeepers	5,693	5,696	53,732	9.43	18
19	Laundry	3,905	4,332	35,277	8.14	19
20	Administrator	2,064	2,200	63,475	28.85	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,963	2,691	31,992	11.89	23
24	Clerical	1,320	1,660	22,196	13.37	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					31
32	Other Health C: MDS, ward clerk	2,659	3,110	51,230	16.47	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	85,670	94,494	$ 1,157,038 *	$ 12.24	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	MONTHLY	$ 8,836	1-3	35
36	Medical Director	MONTHLY	24,000	9-3	36
37	Medical Records Consultant	24	1,530	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	MONTHLY	1,353	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		325	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	24	2,450	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	48	$ 38,494		49

C. CONTRACT NURSES

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
WARREN DICK	ADMINISTRATOR	0	$ 3,975
CATHRINE BROOKSHIRE	ADMINISTRATOR	0	59,500
	OTHER ADMIN		0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,475

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		35,928
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 35,928

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,191
Unemployment Compensation Insurance	13,330
FICA Taxes	88,474
Employee Health Insurance	3,970
Employee Meals	5,804
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	4,400
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)	$ 146,169

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	$
Advertising: Employee Recruitment	1,130
Health Care Worker Background Check	1,135
(Indicate # of checks performed 76)	
Patient Background Checks 27	655
TRUST/FRANCHISE/CONTRIB/ETC	1,295
MARKETING/ADV/PROMO	8,080
LICENSES/DUES/SUBSCRIPTIONS	4,774
MGMT CO ALLOC	
TRUST/FRANCHISE/CONTRIB/ETC	(1,295)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,977)
Yellow page advertising	(1,103)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,694

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 TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

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	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTER # 0035642 Report Period Beginning: 01/01/2010 Ending: 12/31/2010

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC. $3289**

(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. $ **8,378** 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 NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **30,113**
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. $ **5,804** 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 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.