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.

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

I. IDPH License ID Number: 0035642

Facility Name: TRANSITIONS NURSING AND REHAB CENTRE

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: 07/01/1989

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: BILL WEEAKS **Telephone Number:** (217) 528-2244
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROBERT HEDGES
(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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		75	1,453	1,528	8
9	SNF/PED					9
10	ICF	9,659	466		10,125	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,659	541	1,453	11,653	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.05%

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 07/01/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1989 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 1,453

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

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	105,033	7,146	3,893	116,072		116,072		116,072			1
2	Food Purchase		69,092		69,092	(7,667)	61,425	(684)	60,741			2
3	Housekeeping	59,698	6,335		66,033		66,033		66,033			3
4	Laundry	24,598	3,219		27,817		27,817		27,817			4
5	Heat and Other Utilities			62,133	62,133		62,133	887	63,020			5
6	Maintenance	22,177	5,550	25,778	53,505		53,505	3,888	57,393			6
7	Other (specify):* SCAVENGER			9,388	9,388		9,388		9,388			7
8	**TOTAL General Services**	211,506	91,342	101,192	404,040	(7,667)	396,373	4,091	400,464			8
	B. Health Care and Programs											
9	Medical Director			16,500	16,500		16,500		16,500			9
10	Nursing and Medical Records	667,756	43,922	15,787	727,465		727,465	6,280	733,745			10
10a	Therapy	28,539			28,539		28,539		28,539			10a
11	Activities	48,445	1,697	1,412	51,554		51,554		51,554			11
12	Social Services	26,050		3,694	29,744		29,744		29,744			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	770,790	45,619	37,393	853,802		853,802	6,280	860,082			16
	C. General Administration											
17	Administrative	59,585			59,585		59,585	37,618	97,203			17
18	Directors Fees											18
19	Professional Services			18,140	18,140		18,140	7,375	25,515			19
20	Dues, Fees, Subscriptions & Promotions			19,653	19,653		19,653	(10,545)	9,108			20
21	Clerical & General Office Expenses	40,262	8,301	16,160	64,723		64,723	13,557	78,280			21
22	Employee Benefits & Payroll Taxes			135,309	135,309	7,667	142,976	19,931	162,907			22
23	Inservice Training & Education			1,025	1,025		1,025	20	1,045			23
24	Travel and Seminar							2,126	2,126			24
25	Other Admin. Staff Transportation		(729)	8,639	7,910		7,910	(2,411)	5,499			25
26	Insurance-Prop.Liab.Malpractice			32,108	32,108		32,108	892	33,000			26
27	Other (specify):*			56,767	56,767		56,767	(56,767)				27
28	**TOTAL General Administration**	99,847	7,572	287,801	395,220	7,667	402,887	11,796	414,683			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,082,143	144,533	426,386	1,653,062		1,653,062	22,167	1,675,229			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 Number TRANSITIONS NURSING AND REHAB CENTRE #0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,772	9,772		9,772	24,831	34,603			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,522	10,522		10,522	79,542	90,064			32
33	Real Estate Taxes			14,063	14,063		14,063	816	14,879			33
34	Rent-Facility & Grounds			138,188	138,188		138,188	(138,188)				34
35	Rent-Equipment & Vehicles			8,610	8,610		8,610		8,610			35
36	Other (specify):*											36
37	**TOTAL Ownership**			181,155	181,155		181,155	(32,999)	148,156			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		76,621	219,365	295,986		295,986		295,986			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**		76,621	249,478	326,099		326,099		326,099			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,082,143	221,154	857,019	2,160,316		2,160,316	(10,832)	2,149,484			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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	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	6,138	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(684)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(28,665)	27		18
19	Entertainment				19
20	Contributions	(176)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,742)	27		24
25	Fund Raising, Advertising and Promotional	(10,161)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(286)	27		28
29	Other-Attach Schedule SEE ATTACHED	(21,490)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (80,066)		$	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)	69,234		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 69,234		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (10,832)		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 CENTRE

ID# 0035642

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	CASUALTY LOSS	$ (2,898)	27	1
2	MARKETING TRAVEL	(2,411)	25	2
3	MARKETING SALARY	(15,681)	21	3
4	CHAMBER OF COMMERCE	(500)	20	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**	(21,490)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE **#** 0035642 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	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	(684)	0	0	0	0	0	0	0	0	0	0	(684)	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	887	0	0	0	0	0	0	0	0	0	887	5
6	Maintenance	0	3,888	0	0	0	0	0	0	0	0	0	3,888	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(684)	4,775	0	0	0	0	0	0	0	0	0	4,091	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,280	0	0	0	0	0	0	0	0	0	6,280	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	6,280	0	0	0	0	0	0	0	0	0	6,280	16
	C. General Administration													
17	Administrative	0	37,618	0	0	0	0	0	0	0	0	0	37,618	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,073	302	0	0	0	0	0	0	0	0	7,375	19
20	Fees, Subscriptions & Promotions	(10,661)	116	0	0	0	0	0	0	0	0	0	(10,545)	20
21	Clerical & General Office Expenses	(15,681)	29,153	85	0	0	0	0	0	0	0	0	13,557	21
22	Employee Benefits & Payroll Taxes	0	19,931	0	0	0	0	0	0	0	0	0	19,931	22
23	Inservice Training & Education	0	20	0	0	0	0	0	0	0	0	0	20	23
24	Travel and Seminar	0	2,126	0	0	0	0	0	0	0	0	0	2,126	24
25	Other Admin. Staff Transportation	(2,411)	0	0	0	0	0	0	0	0	0	0	(2,411)	25
26	Insurance-Prop.Liab.Malpractice	0	892	0	0	0	0	0	0	0	0	0	892	26
27	Other (specify):*	(56,767)	0	0	0	0	0	0	0	0	0	0	(56,767)	27
28	**TOTAL General Administration**	(85,520)	96,929	387	0	0	0	0	0	0	0	0	11,796	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(86,204)	107,984	387	0	0	0	0	0	0	0	0	22,167	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES	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	6,138	0	793	17,900	0	0	0	0	0	0	0	24,831	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,475	78,067	0	0	0	0	0	0	0	79,542	32
33	Real Estate Taxes	0	0	816	0	0	0	0	0	0	0	0	816	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	6,138	0	3,084	(42,221)	0	0	0	0	0	0	0	(32,999)	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)	(80,066)	107,984	3,471	(42,221)	0	0	0	0	0	0	0	(10,832)	45

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT HEDGES	50	DOCTORS NURSING	SALEM	HI CARE MGMT	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	50	EVERGREEN NURSING	EFFINGHAM	H&I PROPERTIES	SPRINGFIELD	REAL ESTATE
		DOUGLAS NURSING	MATTOON	HEALTHCARE	SPRINGFIELD	NURSE CONSULT
		TAMMERLANE HEALTHCARE	STERLING	HORIZONS		
		WESTERN, NORTHWESTERN, NORTHEASTERN	MISSOURI			
		NURSING				

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	21	HOME OFFICE EXPENSE	$ 1,000	HI CARE MANAGEMENT		$	$ (1,000)	1
2	V	6	MAINTENANCE		HI CARE MANAGEMENT		3,888	3,888	2
3	V	5	UTILITIES		HI CARE MANAGEMENT		887	887	3
4	V	10	NURSING		HI CARE MANAGEMENT		6,280	6,280	4
5	V	17	ADMINISTRATION		HI CARE MANAGEMENT		37,618	37,618	5
6	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		30,153	30,153	6
7	V	19	PROFESSIONAL SERVICES		HI CARE MANAGEMENT		7,073	7,073	7
8	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		116	116	8
9	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		20	20	9
10	V	24	TRAVEL		HI CARE MANAGEMENT		2,126	2,126	10
11	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		892	892	11
12	V	22	PAYROLL TAX ABD BENEFITS		HI CARE MANAGEMENT		19,931	19,931	12
13	V								13
14	Total			$ 1,000			$ 108,984	$ * 107,984	14

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES (HOME OFFICE)		$ 793	$ 793	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		1,475	1,475	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		816	816	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES (HOME OFFICE)		302	302	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		85	85	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			$			$ 3,471	$ * 3,471	39

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 138,188	H&I PROPERTIES (FACILITY)		$	$ (138,188)	15
16	V	30	DEPRECIATION		H&I PROPERTIES (FACILITY)		17,900	17,900	16
17	V	32	INTEREST		H&I PROPERTIES (FACILITY)		78,067	78,067	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			$ 95,967	$ * (42,221)	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: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50.00				SALARY	$ 15,660	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50.00				SALARY	15,020	17-7	2
3	MARTHA IRVINE	BOOKKEEPING						SALARY	1,170	21-7	3
4	DEREK HEDGES	VP OPERATIONS			SEE ATTACHED			SALARY	6,938	17-7	4
5					SCHEDULE						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 38,788		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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: HI CARE MANAGEMENT
Street Address: 1625 S 6TH ST
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	143,838	8	$ 47,997	$ 38,912	11,653	$ 3,888	1
2	5	UTILITIES	PER RESIDENT DAY	143,838	8	10,952		11,653	887	2
3	10	NURSING	PER RESIDENT DAY	143,838	8	77,520	77,520	11,653	6,280	3
4	17	ADMINISTRATION	PER RESIDENT DAY	143,838	8	464,334	464,334	11,653	37,618	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	143,838	8	372,195	290,523	11,653	30,153	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	143,838	8	87,301		11,653	7,073	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	143,838	8	1,428		11,653	116	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	143,838	8	250		11,653	20	8
9	24	TRAVEL	PER RESIDENT DAY	143,838	8	26,248		11,653	2,126	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	143,838	8	11,015		11,653	892	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	143,838	8	246,018		11,653	19,931	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					$ 1,345,258	$ 871,289		$ 108,984	25

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: H&I PROPERTIES (HOME OFFICE)
Street Address: 1625 S 6TH ST
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 LICENSE BED	564	8	$ 8,134	$	55	$ 793	1
2	32	INTEREST	PER LICENSE BED	564	8	15,128		55	1,475	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	564	8	8,372		55	816	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	564	8	3,100		55	302	4
5	21	OFFICE EXPENSE	PER LICENSE BED	564	8	869		55	85	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					$ 35,603	$		$ 3,471	25

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	COLE TAYLOR (HI PROP)		X	MORTGAGE (FACILITY)	$10,728.90	8/3/2005	$ 1,410,500	$ 1,157,413	08/15/2015	0.0650	$ 78,076	1
2	US BANK (HI PROP)		X	MORTGAGE (HOME OFFC)		6/29/2005		22,400	06/29/2012	0.0635	1,475	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		215,000	REVOLV	PRIME +	10,513	6
7												7
8												8
9	TOTAL Facility Related				$10,728.90		$ 1,410,500	$ 1,394,813			$ 90,064	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,410,500	$ 1,394,813			$ 90,064	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **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.)**

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 11,579	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.)		$ 13,229	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,650	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 13,229	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.		$ 14,879	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	16,196	8
	2007	15,804	9
	2008	10,642	10
	2009	10,763	11
	2010	13,229	12

CURRENT YEAR ACCRUAL IS BASED ON PRIOR YEAR ACTUAL

FOR BHF USE ONLY

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

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TRANSITIONS NURSING AND REHAB CENTRE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035642

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

TELEPHONE (217) 528-2244 FAX #: (217) 528-4115

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

Enter the tax index number and real estate tax assessed for 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-27-401-002	NURSING HOME	$ 12,413.12	$ 12,413.12
2.	22-03.0-107-018	HOME OFFICE	$ 5,029.40	$ 490.00
3.	22-.03.0-107-017	HOME OFFICE	$ 3,342.98	$ 326.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 20,785.50	$ 13,229.12

B. **Real Estate Tax Cost Allocations**

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

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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? [ ] (a) Own the Facility [X] (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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	55			1998	$ 698,118	$ 17,900	39	$ 17,900	$	$ 221,532	4
5											5
6	H&I										6
7	PROP										7
8	OFFC BLD			2005	25,637	793	39	793			8
	Improvement Type**										
9	PARKING LOT IMPROVEMENTS			1992	17,677	561	31.5	561		10,934	9
10	CURTAIN TRACKS			1993	5,650	179	31.5	179		3,394	10
11	REWIRING WORK			1996	6,043	155	39	155		2,422	11
12	ROOF			1997	66,564	1,707	39	1,707		24,396	12
13	OUTDOOR FLOODLIGHTS			1997	2,856	73	39	73		1,025	13
14	HANDRAIL & WALL GUARDS			1999	2,524	65	39	65		815	14
15	STORAGE BARN			1999	2,100	54	39	54		677	15
16	BACKFLOW PREVENTER			2000	1,696	62	27.5	62		715	16
17	ROOF			2000	2,680	97	27.5	97		1,120	17
18	NEW WATER HEATER			2001	3,096	113	27.5	113		1,191	18
19	ALARM SYSTEM			2001	5,013	182	27.5	182		1,919	19
20	OVERBED LIGHT			2001	3,687	134	27.5	134		1,413	20
21	CARPET			2001	1,730		5			1,730	21
22	WATER HEATER TANK			2002	1,678	61	27.5	61		582	22
23	ALARM SYSTEM			2002	4,991	182	27.5	182		1,737	23
24	WATER HEATER			2003	2,846	103	27.5	103		880	24
25	WATER HEATER			2004	5,299	193	27.5	193		1,504	25
26	WINDOWS			2005	35,827	1,303	27.5	1,303		7,818	26
27	SMOKE DETECTORS			2005	1,754	64	27.5	64		419	27
28	STEEL FIRE DOOR			2005	1,974	72	27.5	72		471	28
29	FIRE SYSTEM			2005	1,769	64	27.5	64		418	29
30	CARPETING AND TILING			2006	13,437	489	27.5	489		2,831	30
31	WATER SOFTENER			2006	3,425	124	27.5	124		719	31
32	GENERATOR			2006	49,050	1,784	27.5	1,784		9,292	32
33	WATER HEATER			2007	5,007	182	27.5	182		827	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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	2009	$ 3,691	$ 134	27.5	$ 134	$	$ 385	37
38	FLOORING	2009	5,152	494	5	1,030	536	3,090	38
39	FLOORING	2009	2,809	270	5	562	292	1,686	39
40	MOULDINGS FOR DOORWAYS	2010	4,000	42	27.5	42		84	40
41									41
42	HOLDING TANK AND PIPING	2011	3,293	4	27.5	4		4	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)		$ 991,073	$ 27,640		$ 28,468	$ 828	$ 306,030	70

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 60,419	$ 564	$ 5,718	$ 5,154	10 YRS	$ 49,044	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	47,774					47,774	73
74								74
75	TOTALS	$ 108,193	$ 564	$ 5,718	$ 5,154		$ 96,818	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		95 BUICK CENTIRY	2000	$ 6,181	$	$	$		$ 6,181	76
77		93 FORD WHEEL CH VAN	2008	2,500	261	417	156		1,668	77
78										78
79										79
80	TOTALS			$ 8,681	$ 261	$ 417	$ 156		$ 7,849	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)	$ 1,198,144	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,465	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,603	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,138	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 410,697	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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: H&I PROPERTIES
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		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.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 8,610 Description: SEE ATTACHED SCHEDULE
(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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

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

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

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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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	39-2	hrs	$		$ 91,304	$		$ 91,304	1
2	Licensed Speech and Language Development Therapist	39-2	hrs			26,945			26,945	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	hrs			101,116			101,116	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				76,621		76,621	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			$		$ 219,365	$ 76,621		$ 295,986	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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2011 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 53,543	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (25,000))	369,847		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	6,396		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)**	$ 429,786	$	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	267,318		15
16	Equipment, at Historical Cost	114,374		16
17	Accumulated Depreciation (book methods)	(200,846)		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)**	$ 180,846	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 610,632	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 795,844	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	215,000		29
30	Accrued Salaries Payable	54,569		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,817		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,413		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,079,643	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,340,583		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)**	$ 1,340,583	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,420,226	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,809,594)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 610,632	$	48

***(See instructions.)**

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,612,240)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,612,240)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(197,354)	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)**	$ (197,354)	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)**	$ (1,809,594)	24 *

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRI # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,588,472	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,588,472	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	374,490	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 374,490	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***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,962,962	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	404,040	31
32	Health Care	853,802	32
33	General Administration	395,220	33
	B. Capital Expense		
34	Ownership	181,155	34
	C. Ancillary Expense		
35	Special Cost Centers	295,986	35
36	Provider Participation Fee	30,113	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,160,316	40
41	**Income before Income Taxes (line 30 minus line 40)****	(197,354)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (197,354)	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 IS 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 CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage
1	Director of Nursing	1,981	2,045	$ 54,030	$ 26.42
2	Assistant Director of Nursing				
3	Registered Nurses	3,975	4,168	93,958	22.54
4	Licensed Practical Nurses	8,526	9,408	188,527	20.04
5	CNAs & Orderlies	25,345	28,044	260,993	9.31
6	CNA Trainees				
7	Licensed Therapist				
8	Rehab/Therapy Aides	1,751	2,191	28,539	13.03
9	Activity Director	1,833	2,096	27,021	12.89
10	Activity Assistants	1,961	2,222	21,424	9.64
11	Social Service Workers	1,818	2,143	26,050	12.16
12	Dietician				
13	Food Service Supervisor	1,916	2,163	22,388	10.35
14	Head Cook	3,451	3,824	32,042	8.38
15	Cook Helpers/Assistants	5,483	6,036	50,603	8.38
16	Dishwashers				
17	Maintenance Workers	1,823	2,077	22,177	10.68
18	Housekeepers	6,133	6,838	59,698	8.73
19	Laundry	2,639	2,938	24,598	8.37
20	Administrator	2,035	2,091	59,585	28.50
21	Assistant Administrator				
22	Other Administrative				
23	Office Manager	1,997	2,313	24,581	10.63
24	Clerical	1,009	1,089	15,681	14.40
25	Vocational Instruction				
26	Academic Instruction				
27	Medical Director				
28	Qualified MR Prof. (QMRP)				
29	Resident Services Coordinator				
30	Habilitation Aides (DD Homes)				
31	Medical Records	1,574	1,917	17,564	9.16
32	Other Health C: (MDS,Ward Clk)	1,852	2,488	52,684	21.18
33	Other(specify)				
34	TOTAL (lines 1 - 33)	77,102	86,091	$ 1,082,143 *	$ 12.57

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	106	$ 3,893	1-3
36	Medical Director	MONTHLY	16,500	9-3
37	Medical Records Consultant	30	1,980	10-3
38	Nurse Consultant			
39	Pharmacist Consultant	MONTHLY	1,170	10-3
40	Physical Therapy Consultant			
41	Occupational Therapy Consultant			
42	Respiratory Therapy Consultant			
43	Speech Therapy Consultant			
44	Activity Consultant	MONTHLY	1,412	11-3
45	Social Service Consultant	MONTHLY	1,413	12-3
46	Other(specify) PSYCHIATRIC	MONTHLY	7,500	10-3
47				
48				
49	TOTAL (lines 35 - 48)	136	$ 33,868	

C. CONTRACT NURSES

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

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

** See instructions.

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LINDA COX	ADMINISTRATOR	0	$ 12,833
NORM GROSS	ADMINSTRATOR	0	46,752
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 59,585

B. Administrative - Other

Description	Amount
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 ATTACHED SCHEDULE		25,515
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 25,515

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,237
Unemployment Compensation Insurance	14,158
FICA Taxes	86,247
Employee Health Insurance	12,459
Employee Meals	7,667
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS OTHER	4,710
PENSION PLAN	5,429
TOTAL (agree to Schedule V, line 22, col.8)	$ 162,907

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	448
Health Care Worker Background Check	
(Indicate # of checks performed 41)	1,280
Patient Background Checks 34	84
SEE ATTACHED SCHEDULE	5,306
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,108

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
SEE ATTACHED SCHEDULE	2,126
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,126

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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. **IHCA $2530**

(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?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,635** 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 **X** 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. $ **7,667** Has any meal income been offset against related costs? **NO** 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? **YES**
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.

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

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

TOTAL FOOD PURCHASE	$ 69,092
LESS SALES TAX	$ (684)
NET FOOD	$ 68,408
TOTAL PATIENT CENSUS	11,653
MEALS PER DAY	3
TOTAL PATIENT MEALS	34,959
EMPLOYEES MEALS PER DAY	12
DAYS PER YEAR	365
TOTAL EMPLOYEE MEALS	4,413
TOTAL MEALS PER YEAR	39,372
COST PER MEAL	$ 1.74
TOTAL EMPLOYEE MEAL COST	$ 7,667

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
CONCENTRATORS	$ 202
BEDS	$ 4,700
IV PUMPS	$ 1,016
DISHWASHER	$ 1,037
SCAFFOLDING	$ 240
POSTAGE MACHINE	$ 235
COPIER	$ 865
PORTABLE BLD	$ 315
TOTAL	$ 8,610

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	AMOUNT
MDI	IT	$ 2,781
ACCU MED	SOFTWARE SUPPORT	$ 3,780
ILLINI TECH	IT	$ 242
IIT SOURCETECH	IT	$ 545
LTC SOLUTIONS	PULSE OX AUDIT	$ 891
KBKB	ACCOUNTING/TAX	$ 10,659
RICHARD PEELO	COST REPORTS	$ 3,000
COLE TAYLOR	LEGAL	$ 793
BPC	401K ADMIN	$ 557
CT CORP	CORP AGENT	$ 55
ILLINOIS DEP OF REGULATION		$ 10
MARGEL PEDDICORD	CONSULTING	$ 138
STRATTON	LEGAL	$ 1,184
SANDBERG	LEGAL	$ 82
IVANS	SOFTWARE SUPPORT	$ 382
EMDEON	IT	$ 80
PEHLMAN	ACCTG SVC	$ 336
TOTALS		$ 25,515

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	AMOUNT
IHCA	DUES	$ 2,530
EHEALTH	CAREWATCH	$ 2,046
SAULK VALLEY NEWS PAPER	NEWSPAPER	$ 196
ILLINOIS SOS	REGISTRATION	$ 100
ILLINOIS SOS	REGISTRATION	$ 158
WHITESIDE COUNTY	FOOD PERMIT	$ 170
ALEXANDER HAMILTON	EMPLOYEE LAW	$ 4
WOLTERS	OSHA GUIDE	$ 11
MEDPASS	MANUALS	$ 34
AICPA	ACCTG GUIDE	$ 49
TAX	TAX	$ 8
TOTALS		$ 5,306

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

TRAVEL AND SEMINAR

Item	Amount
IHCA	$ 112
INHAA	$ 8
IPC	$ 13
LTCNA	$ 20
CORP DON	$ 1,973
TOTAL	$ 2,126

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	AMOUNT
TRANSPORT VAN	$ 3,277
NORM GROSS - ADMINISTRATOR	$ 926
HAROLD BLANTON - FACILITIES	$ 421
MISC OTHER EMPLOYEES	$ 875
TOTALS	$ 5,499