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.

2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

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:** BILL WEEAKS
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 1/1/2012 to 12/31/2012 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: 1/1/2012 Ending: 12/31/2012

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	20,130	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	20,130	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	369	8	1,449	1,826	8
9	SNF/PED					9
10	ICF	8,610	741		9,351	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,979	749	1,449	11,177	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.52%

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 1,322

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: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CI # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	105,278	6,636	4,451	116,365		116,365		116,365			1
2	Food Purchase		61,166		61,166	(7,059)	54,107	(612)	53,495			2
3	Housekeeping	56,920	7,884		64,804		64,804		64,804			3
4	Laundry	20,684	3,586		24,270		24,270		24,270			4
5	Heat and Other Utilities			75,267	75,267		75,267	833	76,100			5
6	Maintenance	24,121	10,527	24,035	58,683		58,683	4,621	63,304			6
7	Other (specify):* SCAVENGER			13,670	13,670		13,670		13,670			7
8	**TOTAL General Services**	207,003	89,799	117,423	414,225	(7,059)	407,166	4,842	412,008			8
	B. Health Care and Programs											
9	Medical Director			23,700	23,700		23,700		23,700			9
10	Nursing and Medical Records	630,092	43,658	8,333	682,083		682,083	7,836	689,919			10
10a	Therapy	29,132			29,132		29,132		29,132			10a
11	Activities	50,863	1,806	1,250	53,919		53,919		53,919			11
12	Social Services	24,797		4,929	29,726		29,726		29,726			12
13	CNA Training											13
14	Program Transportation			200	200		200		200			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	734,884	45,464	38,412	818,760		818,760	7,836	826,596			16
	C. General Administration											
17	Administrative	58,778			58,778		58,778	47,629	106,407			17
18	Directors Fees											18
19	Professional Services			(48,747)	(48,747)		(48,747)	66,014	17,267			19
20	Dues, Fees, Subscriptions & Promotions			28,274	28,274		28,274	(16,492)	11,782			20
21	Clerical & General Office Expenses	59,197	8,271	14,332	81,800		81,800	(2,497)	79,303			21
22	Employee Benefits & Payroll Taxes			188,461	188,461	7,059	195,520	20,394	215,914			22
23	Inservice Training & Education			944	944		944	296	1,240			23
24	Travel and Seminar			2,500	2,500		2,500	1,600	4,100			24
25	Other Admin. Staff Transportation			18,852	18,852		18,852	(5,907)	12,945			25
26	Insurance-Prop.Liab.Malpractice			31,279	31,279		31,279	1,404	32,683			26
27	Other (specify):*			59,993	59,993		59,993	(59,993)				27
28	**TOTAL General Administration**	117,975	8,271	295,888	422,134	7,059	429,193	52,448	481,641			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,059,862	143,534	451,723	1,655,119		1,655,119	65,126	1,720,245			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: 1/1/2012 Ending: 12/31/2012

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			9,378	9,378		9,378	23,548	32,926			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,674	11,674		11,674	69,861	81,535			32
33	Real Estate Taxes			12,313	12,313		12,313	1,064	13,377			33
34	Rent-Facility & Grounds			138,188	138,188		138,188	(138,188)				34
35	Rent-Equipment & Vehicles			17,408	17,408		17,408		17,408			35
36	Other (specify):*											36
37	**TOTAL Ownership**			188,961	188,961		188,961	(43,715)	145,246			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			265,578	265,578		265,578		265,578			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			136,123	136,123		136,123		136,123			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			401,701	401,701		401,701		401,701			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,059,862	143,534	1,042,385	2,245,781		2,245,781	21,411	2,267,192			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: 1/1/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,760	30		9
10	Interest and Other Investment Income	(205)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(612)	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	(5,020)	27		18
19	Entertainment				19
20	Contributions	(286)	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	(55,002)	27		24
25	Fund Raising, Advertising and Promotional	(15,116)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	12,541			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (58,940)		$	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)	80,351		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 80,351		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 21,411		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: 1/1/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON ALLOWABLE CASUALTY	$ (283)	27	1
2	EMPLOYEE MEAL INCOME	598	27	2
3	MARKETING TRAVEL	(5,907)	25	3
4	MARKETING SALARY	(35,087)	21	4
5	HEALTH CARE HORIZONS EXP REVERSAL	58,475	19	5
6	PRIOR YR NON INCLUDABLE COSTS	(1,022)	19	6
7	NON INCLUDABLE MARKETING COSTS	(346)	19	7
8	NON INCLUDABLE LEGAL COSTS	(1,054)	19	8
9	NON INCLUDABLE MARKETING COSTS	(472)	20	9
10	CHAMBER DUES	(550)	20	10
11	ROTARY DUES	(265)	20	11
12	NON INCLUDABLE MARKETING COSTS	(1,546)	20	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**	12,541		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(612)	0	0	0	0	0	0	0	0	0	0	(612)	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	833	0	0	0	0	0	0	0	0	0	833	5
6	Maintenance	0	4,621	0	0	0	0	0	0	0	0	0	4,621	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(612)	5,454	0	0	0	0	0	0	0	0	0	4,842	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	7,836	0	0	0	0	0	0	0	0	0	7,836	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	7,836	0	0	0	0	0	0	0	0	0	7,836	16
	C. General Administration													
17	Administrative	0	47,629	0	0	0	0	0	0	0	0	0	47,629	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	56,053	9,590	371	0	0	0	0	0	0	0	0	66,014	19
20	Fees, Subscriptions & Promotions	(17,949)	1,457	0	0	0	0	0	0	0	0	0	(16,492)	20
21	Clerical & General Office Expenses	(35,087)	32,440	150	0	0	0	0	0	0	0	0	(2,497)	21
22	Employee Benefits & Payroll Taxes	0	20,394	0	0	0	0	0	0	0	0	0	20,394	22
23	Inservice Training & Education	0	296	0	0	0	0	0	0	0	0	0	296	23
24	Travel and Seminar	0	1,600	0	0	0	0	0	0	0	0	0	1,600	24
25	Other Admin. Staff Transportation	(5,907)	0	0	0	0	0	0	0	0	0	0	(5,907)	25
26	Insurance-Prop.Liab.Malpractice	0	1,404	0	0	0	0	0	0	0	0	0	1,404	26
27	Other (specify):*	(59,993)	0	0	0	0	0	0	0	0	0	0	(59,993)	27
28	**TOTAL General Administration**	(62,883)	114,810	521	0	0	0	0	0	0	0	0	52,448	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,495)	128,100	521	0	0	0	0	0	0	0	0	65,126	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,760	0	894	17,894	0	0	0	0	0	0	0	23,548	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(205)	0	1,408	68,658	0	0	0	0	0	0	0	69,861	32
33	Real Estate Taxes	0	0	1,064	0	0	0	0	0	0	0	0	1,064	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	4,555	0	3,366	(51,636)	0	0	0	0	0	0	0	(43,715)	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)	(58,940)	128,100	3,887	(51,636)	0	0	0	0	0	0	0	21,411	45

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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		

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	6	MAINTENANCE	$	HI CARE MANAGEMENT		$ 4,621	$ 4,621	1
2	V	5	UTILITIES		HI CARE MANAGEMENT		833	833	2
3	V	10	NURSING		HI CARE MANAGEMENT		7,836	7,836	3
4	V	17	ADMINISTRATION		HI CARE MANAGEMENT		47,629	47,629	4
5	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		32,440	32,440	5
6	V	19	PROFESSIONAL SERVICES		HI CARE MANAGEMENT		9,590	9,590	6
7	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		1,457	1,457	7
8	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		296	296	8
9	V	24	TRAVEL		HI CARE MANAGEMENT		1,600	1,600	9
10	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		1,404	1,404	10
11	V	22	PAYROLL TAX ABD BENEFITS		HI CARE MANAGEMENT		20,394	20,394	11
12	V								12
13	V								13
14	Total			$			$ 128,100	$ * 128,100	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: 1/1/2012 Ending: 12/31/2012

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)		$ 894	$ 894	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		1,408	1,408	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		1,064	1,064	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES (HOME OFFICE)		371	371	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		150	150	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			$			$ 3,887	$ * 3,887	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: 1/1/2012 Ending: 12/31/2012

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)		17,894	17,894	16
17	V	32	INTEREST		H&I PROPERTIES (FACILITY)		68,658	68,658	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			$ 86,552	$ * (51,636)	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: 1/1/2012 Ending: 12/31/2012

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				SALARY	$ 19,157	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50				SALARY	18,374	17-7	2
3	MARTHA IRVINE	BOOKKEEPING						SALARY	1,432	21-7	3
4	DEREK HEDGES	VP OPERATIONS			SEE ATTACHED			SALARY	8,666	17-7	4
5					SCHEDULE						5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 47,629		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: 1/1/2012 Ending: 2/31/2012

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	112,777	5	$ 46,629	$ 39,723	11,177	$ 4,621	1
2	5	UTILITIES	PER RESIDENT DAY	112,777	5	8,403		11,177	833	2
3	10	NURSING	PER RESIDENT DAY	112,777	5	79,070	79,070	11,177	7,836	3
4	17	ADMINISTRATION	PER RESIDENT DAY	112,777	5	480,583	480,583	11,177	47,629	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	112,777	5	327,320	265,760	11,177	32,440	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	112,777	5	96,762		11,177	9,590	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	112,777	5	14,702		11,177	1,457	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	112,777	5	2,984		11,177	296	8
9	24	TRAVEL	PER RESIDENT DAY	112,777	5	16,146		11,177	1,600	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	112,777	5	14,166		11,177	1,404	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	112,777	5	205,777		11,177	20,394	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					$ 1,292,542	$ 865,136		$ 128,100	25

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

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	444	5	$ 7,213	$	55	$ 894	1
2	32	INTEREST	PER LICENSE BED	444	5	11,364		55	1,408	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	444	5	8,587		55	1,064	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	444	5	2,993		55	371	4
5	21	OFFICE EXPENSE	PER LICENSE BED	444	5	1,214		55	150	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					$ 31,371	$		$ 3,887	25

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CI # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	COLE TAYLOR (HI PROP)		X	MORTGAGE (FACILITY)	$10,729.00	8/3/2005	$ 1,410,500	$ 1,108,053	08/15/2015	0.0650	$ 68,658	1
2	US BANK (HI PROP)		X	MORTGAGE (HOME OFFC)		6/29/2005		27,196	06/29/2017	0.0425	1,408	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		217,000	REVOLV	PRIME +	11,674	6
7												7
8												8
9	TOTAL Facility Related				$10,729.00		$ 1,410,500	$ 1,352,249			$ 81,740	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	$ 1,352,249			$ 81,740	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: 1/1/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 13,229	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.)		$ 13,427	2
3. Under or (over) accrual (line 2 minus line 1).		$ 198	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 13,179	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.		$ 13,377	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	15,804	8
	2008	10,642	9
	2009	10,763	10
	2010	13,229	11
	2011	13,427	12

CURRENT YEAR ACCRUAL IS BASED ON PRIOR YEAR ACTUAL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	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.

2011 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 2011 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 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-27-401-002	NURSING HOME	$ 12,363.20	$ 12,363.20
2.	22-03.0-107-018	HOME OFFICE	$ 5,158.22	$ 639.15
3.	22-.03.0-107-017	HOME OFFICE	$ 3,428.58	$ 424.83
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 20,950.00	$ 13,427.18

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 _____ 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 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

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: 1/1/2012 Ending: 12/31/2012

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	7,185	2
3	TOTALS	67,000		$ 90,480	3

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	$ 17,894	39	$ 17,894	$	$ 239,426	4
5											5
6	H&I										6
7	PROP										7
8	OFFC BLD			2005	32,566	894	39	894			8
	Improvement Type**										
9	PARKING LOT IMPROVEMENTS			1992	17,677	561	31.5	561		11,477	9
10	CURTAIN TRACKS			1993	5,650	179	31.5	179		3,574	10
11	REWIRING WORK			1996	6,043	155	39	155		2,577	11
12	ROOF			1997	66,564	1,707	39	1,707		26,102	12
13	OUTDOOR FLOODLIGHTS			1997	2,856	73	39	73		1,098	13
14	HANDRAIL & WALL GUARDS			1999	2,524	74	39	74		889	14
15	STORAGE BARN			1999	2,100	65	39	65		721	15
16	BACKFLOW PREVENTER			2000	1,696	62	27.5	62		777	16
17	ROOF			2000	2,680	97	27.5	97		1,217	17
18	NEW WATER HEATER			2001	3,096	113	27.5	113		1,304	18
19	ALARM SYSTEM			2001	5,013	182	27.5	182		2,101	19
20	OVERBED LIGHT			2001	3,687	134	27.5	134		1,547	20
21	CARPET			2001	1,730		5			1,730	21
22	WATER HEATER TANK			2002	1,678	61	27.5	61		643	22
23	ALARM SYSTEM			2002	4,991	181	27.5	181		1,918	23
24	WATER HEATER			2003	2,846	104	27.5	104		984	24
25	WATER HEATER			2004	5,299	193	27.5	193		1,696	25
26	WINDOWS			2005	35,827	1,303	27.5	1,303		9,283	26
27	SMOKE DETECTORS			2005	1,754	64	27.5	64		483	27
28	STEEL FIRE DOOR			2005	1,974	72	27.5	72		543	28
29	FIRE SYSTEM			2005	1,769	64	27.5	64		482	29
30	CARPETING AND TILING			2006	13,437	489	27.5	489		3,320	30
31	WATER SOFTENER			2006	3,425	124	27.5	124		844	31
32	GENERATOR			2006	49,050	1,783	27.5	1,783		11,076	32
33	WATER HEATER			2007	5,007	182	27.5	182		1,009	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: 1/1/2012 Ending: 12/31/2012

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	$	$ 520	37
38	FLOORING	2009	5,152	296	5	1,030	734	4,120	38
39	FLOORING	2009	2,809	162	5	562	400	2,248	39
40	MOULDINGS FOR DOORWAYS	2010	4,000	145	27.5	145		333	40
41									41
42	HOLDING TANK AND PIPING	2011	3,293	120	27.5	120		135	42
43									43
44	WATER HEATER	2012	5,805	202	27.5	202		202	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)		$ 1,003,807	$ 27,869		$ 29,003	$ 1,134	$ 334,379	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: 1/1/2012 Ending: 12/31/2012

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	$ 39,227	$ 297	$ 3,923	$ 3,626		$ 31,775	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	68,966					68,966	73
74								74
75	TOTALS	$ 108,193	$ 297	$ 3,923	$ 3,626		$ 100,741	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				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	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)	$ 1,202,480	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 28,166	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 32,926	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,760	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 435,120	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: 1/1/2012 Ending: 12/31/2012

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.	/2013	$
13.	/2014	$
14.	/2015	$

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: $ 17,408 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: 1/1/2012 Ending: 12/31/2012

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: 1/1/2012 Ending: 12/31/2012

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-2	hrs	$		$ 88,091	$		$ 88,091	1
2	Licensed Speech and Language Development Therapist	39-2	hrs			20,677			20,677	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-2	hrs			79,394			79,394	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				77,416		77,416	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			$		$ 188,162	$ 77,416		$ 265,578	14

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2012 (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	$ 27,900	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (45,000))	353,923		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,444		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)**	$ 384,267	$	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	273,123		15
16	Equipment, at Historical Cost	108,193		16
17	Accumulated Depreciation (book methods)	(204,043)		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)**	$ 177,273	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 561,540	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 999,301	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	217,000		29
30	Accrued Salaries Payable	49,029		30
31	Accrued Taxes Payable (excluding real estate taxes)	260		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,363		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)**	$ 1,277,953	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,390,583		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)**	$ 1,390,583	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,668,536	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,106,996)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 561,540	$	48

***(See instructions.)**

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,809,594)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,809,594)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(297,405)	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) **ROUNDING**	3	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (297,402)	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)**	$ (2,106,996)	24 *

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTR # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,948,171	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,948,171	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	205	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 205	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)**	$ 1,948,376	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	414,225	31
32	Health Care	818,760	32
33	General Administration	422,134	33
	B. Capital Expense		
34	Ownership	188,961	34
	C. Ancillary Expense		
35	Special Cost Centers	265,578	35
36	Provider Participation Fee	136,123	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,245,781	40
41	**Income before Income Taxes (line 30 minus line 40)****	(297,405)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (297,405)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,135,811	44
45	Private Pay - Net Inpatient Revenue	130,673	45
46	Medicare - Net Inpatient Revenue	650,701	46
47	Other-(specify) INSURANCE	30,986	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,948,171	49

* **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 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: 1/1/2012 Ending: 12/31/2012

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	2,012	2,127	$ 51,931	$ 24.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,120	4,586	107,451	23.43	3
4	Licensed Practical Nurses	6,618	7,328	153,841	20.99	4
5	CNAs & Orderlies	24,823	26,885	253,059	9.41	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,803	2,212	29,132	13.17	8
9	Activity Director	1,949	2,205	28,824	13.07	9
10	Activity Assistants	2,211	2,453	22,039	8.98	10
11	Social Service Workers	1,660	2,040	24,797	12.16	11
12	Dietician					12
13	Food Service Supervisor	1,961	2,198	21,934	9.98	13
14	Head Cook	3,354	3,791	32,508	8.58	14
15	Cook Helpers/Assistants	5,089	5,604	50,836	9.07	15
16	Dishwashers					16
17	Maintenance Workers	1,929	2,213	24,121	10.90	17
18	Housekeepers	5,859	6,426	56,920	8.86	18
19	Laundry	2,311	2,466	20,684	8.39	19
20	Administrator	1,992	2,072	58,778	28.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,950	2,240	24,110	10.76	23
24	Clerical	2,032	2,080	35,087	16.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,944	2,233	20,917	9.37	31
32	Other Health C: MDS,Trans	1,767	2,003	42,893	21.41	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	75,384	83,162	$ 1,059,862 *	$ 12.74	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	109	$ 4,451	1-3	35
36	Medical Director	MONTHLY	18,700	9-3	36
37	Medical Records Consultant	24	1,560	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	1,011	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	1,250	11-3	44
45	Social Service Consultant	16	1,250	12-3	45
46	Other(specify) PSYCHIATRIC	MONTHLY	5,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	165	$ 33,222		49

C. CONTRACT NURSES

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

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NORM GROSS	ADMINISTRATOR	0	$ 58,778
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 58,778

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		17,267
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 17,267

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,736
Unemployment Compensation Insurance	34,076
FICA Taxes	86,202
Employee Health Insurance	16,617
Employee Meals	7,059
Illinois Municipal Retirement Fund (IMRF)*	
PENSION PLAN	5,195
EMPLOYEE BENEFITS OTHER	38,029
TOTAL (agree to Schedule V, line 22, col.8)	$ 215,914

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	1,788
Health Care Worker Background Check (Indicate # of checks performed 31)	1,143
Patient Background Checks 55	1,107
SEE ATTACHED	5,754
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,782

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
CORP DON	1,600
Seminar Expense	
IHCA	2,500
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,100

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TRANSITIONS NURSING AND REHAB CENTRE # 0035642 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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: 1/1/2012 Ending: 12/31/2012

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 $3280**

(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 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,344** 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. $ **136,123**
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. $ **7,059** 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. $

(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 12/31/12

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

TOTAL FOOD PURCHASE	$ 61,166
LESS SALES TAX	$ (612)
NET FOOD	$ 60,554
TOTAL PATIENT CENSUS	11,177
MEALS PER DAY	3
TOTAL PATIENT MEALS	33,531
EMPLOYEES MEALS PER DAY	12
DAYS PER YEAR	366
TOTAL EMPLOYEE MEALS	4,425
TOTAL MEALS PER YEAR	37,956
COST PER MEAL	$ 1.60
TOTAL EMPLOYEE MEAL COST	$ 7,059

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

SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
CONCENTRATORS	$ 1,122
BEDS	$ 8,606
IV PUMPS	$ 1,400
DISHWASHER	$ 2,238
BEVERAGE EQUIP	$ 168
POSTAGE MACHINE	$ 216
COPIER	$ 2,938
PORTABLE BLD	$ 720
TOTAL	$ 17,408

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

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	AMOUNT
MDI	IT	$ 3,574
ACCU MED	SOFTWARE SUPPORT	$ 3,465
IIT SOURCETECH	IT	$ 1,263
LTC SOLUTIONS	PULSE OX AUDIT	$ 372
KBKB	ACCOUNTING/TAX	$ 5,471
BPC	401K ADMIN	$ 209
TALX	TAX	$ 297
HORWOOD MARCUS	LEGAL	$ 513
MARGEL PEDDICORD	CONSULTING	$ 37
STRATTON	LEGAL	$ 1,168
CCH	TAX	$ 26
IVANS	SOFTWARE SUPPORT	$ 379
EMDEON	IT	$ 82
PEHLMAN	ACCTG SVC	$ 411
TOTALS		$ 17,267

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

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	AMOUNT
IHCA	DUES	$ 3,280
EHEALTH	CAREWATCH	$ 2,046
ILLINOIS SOS	REGISTRATION	$ 258
WHITESIDE COUNTY	FOOD PERMIT	$ 170
TOTALS		$ 5,754

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

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	AMOUNT
TRANSPORT VAN	$ 8,329
NORM GROSS - ADMINISTRATOR	$ 1,333
OTHER EMPLOYEES	$ 3,283
TOTALS	$ 12,945