FOR BHF USE

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

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.

I. IDPH License ID Number: 0035642

Facility Name: TRANSITIONS NSG & REHAB CTR

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 1/1/2013 to 12/31/2013 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) 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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	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	806	79	1,182	2,067	8
9	SNF/PED					9
10	ICF	7,263	1,145		8,408	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,069	1,224	1,182	10,475	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 52.18%

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 1,005

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

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	109,010	5,265	4,674	118,949	(335)	118,614		118,614			1
2	Food Purchase		57,722		57,722	(6,011)	51,711	45	51,756			2
3	Housekeeping	39,873	5,975		45,848		45,848		45,848			3
4	Laundry	19,088	3,075		22,163		22,163		22,163			4
5	Heat and Other Utilities			72,088	72,088		72,088	(4,546)	67,542			5
6	Maintenance	22,923	8,622	25,528	57,073	1,596	58,669	3,053	61,722			6
7	Other (specify):* SCAVENGER			15,627	15,627		15,627		15,627			7
8	TOTAL General Services	190,894	80,659	117,917	389,470	(4,750)	384,720	(1,448)	383,272			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	606,039	38,542	26,298	670,879		670,879	1,621	672,500			10
10a	Therapy	29,615			29,615		29,615		29,615			10a
11	Activities	25,491	723	1,250	27,464	35	27,499		27,499			11
12	Social Services	25,912		1,250	27,162		27,162		27,162			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	687,057	39,265	46,798	773,120	35	773,155	1,621	774,776			16
	C. General Administration											
17	Administrative	63,549			63,549		63,549	75,203	138,752			17
18	Directors Fees											18
19	Professional Services			5,672	5,672	236	5,908	10,115	16,023			19
20	Dues, Fees, Subscriptions & Promotions			23,627	23,627		23,627	(11,686)	11,941			20
21	Clerical & General Office Expenses	61,441	6,052	(45,516)	21,977	253	22,230	35,841	58,071			21
22	Employee Benefits & Payroll Taxes			143,929	143,929	6,011	149,940	19,858	169,798			22
23	Inservice Training & Education			1,095	1,095		1,095	300	1,395			23
24	Travel and Seminar							2,219	2,219			24
25	Other Admin. Staff Transportation			15,366	15,366		15,366	(6,187)	9,179			25
26	Insurance-Prop.Liab.Malpractice			12,615	12,615		12,615	14,585	27,200			26
27	Other (specify):*			51,721	51,721		51,721	(51,721)				27
28	TOTAL General Administration	124,990	6,052	208,509	339,551	6,500	346,051	88,527	434,578			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,002,941	125,976	373,224	1,502,141	1,785	1,503,926	88,700	1,592,626			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 NSG & REHAB CTR #0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			11,700	11,700		11,700	23,811	35,511			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,378	8,378		8,378	71,711	80,089			32
33	Real Estate Taxes			12,014	12,014		12,014	1,090	13,104			33
34	Rent-Facility & Grounds			136,234	136,234		136,234	(136,234)				34
35	Rent-Equipment & Vehicles			19,877	19,877	(1,785)	18,092		18,092			35
36	Other (specify):*											36
37	**TOTAL Ownership**			188,203	188,203	(1,785)	186,418	(39,622)	146,796			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		55,758	134,625	190,383		190,383		190,383			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,525	87,525		87,525		87,525			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		55,758	222,150	277,908		277,908		277,908			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,002,941	181,734	783,577	1,968,252		1,968,252	49,078	2,017,330			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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(5,423)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,051	30		9
10	Interest and Other Investment Income	(824)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(608)	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				18
19	Entertainment				19
20	Contributions	(314)	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	(50,777)	27		24
25	Fund Raising, Advertising and Promotional	(11,442)	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	36,127			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (28,210)		$	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)	77,288		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 77,288		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 49,078		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 NSG & REHAB CTR

ID# 0035642

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING TRAVEL	$ (6,187)	25	1
2	MARKETING SALARY	(38,446)	21	2
3	BAD DEBT RECOVERY	6,871	19	3
4	CHAMBER OF COMMERCE	(500)	20	4
5	ROTARY	(132)	20	5
6	REVERSAL OF PRIOR YR HOME OFFICE CHGS	62,000	21	6
7	PRIOR YEAR ADJUSTMENT - INSURANCE	13,750	26	7
8	MARKETING COSTS	(630)	27	8
9	EMPLOYEE MEAL INCOME	653	2	9
10	SAGE AGE MARKETING	(1,082)	19	10
11	AM PROFIT RECOVERY - BAD DEBTS	(170)	19	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**	36,127		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	45	0	0	0	0	0	0	0	0	0	0	45	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	(5,423)	877	0	0	0	0	0	0	0	0	0	(4,546)	5
6	Maintenance	0	3,053	0	0	0	0	0	0	0	0	0	3,053	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,378)	3,930	0	0	0	0	0	0	0	0	0	(1,448)	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	1,621	0	0	0	0	0	0	0	0	0	1,621	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	1,621	0	0	0	0	0	0	0	0	0	1,621	16
	C. General Administration													
17	Administrative	0	75,203	0	0	0	0	0	0	0	0	0	75,203	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	5,619	4,360	136	0	0	0	0	0	0	0	0	10,115	19
20	Fees, Subscriptions & Promotions	(12,074)	388	0	0	0	0	0	0	0	0	0	(11,686)	20
21	Clerical & General Office Expenses	23,554	12,100	187	0	0	0	0	0	0	0	0	35,841	21
22	Employee Benefits & Payroll Taxes	0	19,858	0	0	0	0	0	0	0	0	0	19,858	22
23	Inservice Training & Education	0	300	0	0	0	0	0	0	0	0	0	300	23
24	Travel and Seminar	0	2,219	0	0	0	0	0	0	0	0	0	2,219	24
25	Other Admin. Staff Transportation	(6,187)	0	0	0	0	0	0	0	0	0	0	(6,187)	25
26	Insurance-Prop.Liab.Malpractice	13,750	835	0	0	0	0	0	0	0	0	0	14,585	26
27	Other (specify):*	(51,721)	0	0	0	0	0	0	0	0	0	0	(51,721)	27
28	**TOTAL General Administration**	(27,059)	115,263	323	0	0	0	0	0	0	0	0	88,527	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(32,437)	120,814	323	0	0	0	0	0	0	0	0	88,700	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	5,051	0	894	17,866	0	0	0	0	0	0	0	23,811	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(824)	0	1,231	71,304	0	0	0	0	0	0	0	71,711	32
33	Real Estate Taxes	0	0	1,090	0	0	0	0	0	0	0	0	1,090	33
34	Rent-Facility & Grounds	0	0	0	(136,234)	0	0	0	0	0	0	0	(136,234)	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**	4,227	0	3,215	(47,064)	0	0	0	0	0	0	0	(39,622)	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)**	(28,210)	120,814	3,538	(47,064)	0	0	0	0	0	0	0	49,078	45

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
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. ☐ 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		$ 3,053	$ 3,053	1
2	V	5	UTILITIES		HI CARE MANAGEMENT		877	877	2
3	V	10	NURSING		HI CARE MANAGEMENT		1,621	1,621	3
4	V	17	ADMINISTRATION		HI CARE MANAGEMENT		75,203	75,203	4
5	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		12,100	12,100	5
6	V	19	PROFESSIONAL SERVICES		HI CARE MANAGEMENT		4,360	4,360	6
7	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		388	388	7
8	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		300	300	8
9	V	24	TRAVEL		HI CARE MANAGEMENT		2,219	2,219	9
10	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		835	835	10
11	V	22	PAYROLL TAX ABD BENEFITS		HI CARE MANAGEMENT		19,858	19,858	11
12	V								12
13	V								13
14	Total			$			$ 120,814	$ * 120,814	14

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES (HOME OFFICE)		$ 894	$ 894	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		1,231	1,231	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		1,090	1,090	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES (HOME OFFICE)		136	136	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		187	187	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			$			$ 3,538	$ * 3,538	39

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 136,234	H&I PROPERTIES (FACILITY)		$	$ (136,234)	15
16	V	30	DEPRECIATION		H&I PROPERTIES (FACILITY)		17,866	17,866	16
17	V	32	INTEREST		H&I PROPERTIES (FACILITY)		71,304	71,304	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			$ 136,234			$ 89,170	$ * (47,064)	39

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50	174,621	3.865	9.66	SALARY	$ 18,678	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50	167,484	3.865	9.66	SALARY	17,914	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	13,050	3.865	9.66	SALARY	1,396	17-7	3
4	DEREK HEDGES	VP OPERATIONS	VP OPERATIONS	0.00	84,258	3.865	9.66	SALARY	9,012	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 47,000		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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	108,409	5	$ 31,601	$ 27,116	10,475	$ 3,053	1
2	5	UTILITIES	PER RESIDENT DAY	108,409	5	9,081		10,475	877	2
3	10	NURSING	PER RESIDENT DAY	108,409	5	16,777	16,777	10,475	1,621	3
4	17	ADMINISTRATION	PER RESIDENT DAY	108,409	5	778,304	778,304	10,475	75,203	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	108,409	5	125,226		10,475	12,100	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	108,409	5	45,127		10,475	4,360	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	108,409	5	4,017		10,475	388	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	108,409	5	3,109		10,475	300	8
9	24	TRAVEL	PER RESIDENT DAY	108,409	5	22,964		10,475	2,219	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	108,409	5	8,646		10,475	835	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	108,409	5	205,518		10,475	19,858	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					$ 1,250,370	$ 822,197		$ 120,814	25

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: 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	9,940		55	1,231	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	444	5	8,803		55	1,090	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	444	5	1,095		55	136	4
5	21	OFFICE EXPENSE	PER LICENSE BED	444	5	1,508		55	187	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					$ 28,559	$		$ 3,538	25

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: H&I PROPERTIES-FACILITY
Street Address: 1625 S 6TH STREET
City / State / Zip Code: SPRINGFIELD, IL 62703
Phone Number: ((217) 528-0044
Fax Number: ((217) 528-0412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 17,866	$	1	$ 17,866	1
2	32	INTEREST	DIRECT	1	1	71,304		1	71,304	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 89,170	$		$ 89,170	25

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		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	$ 1,050,610	08/15/2015	0.0650	$ 71,304	1
2	US BANK (HI PROP)		X	MORTGAGE (HOME OFFC)		6/29/2005		25,491	06/29/2017	0.0425	1,231	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV		125,000	REVOLV	PRIME +	8,378	6
7												7
8												8
9	TOTAL Facility Related				$10,729.00		$ 1,410,500	$ 1,201,101			$ 80,913	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	$ 1,201,101			$ 80,913	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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 13,179	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.)		$ 13,279	2
3. Under or (over) accrual (line 2 minus line 1).		$ 100	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 13,004	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.		$ 13,104	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2008	10,642	8
	2009	10,763	9
	2010	13,229	10
	2011	13,427	11
	2012	13,279	12

CURRENT YEAR ACCRUAL IS BASED ON PRIOR YEAR ACTUAL

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TRANSITIONS NSG & REHAB CTR 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 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-27-401-002	NURSING HOME	$ 12,188.54	$ 12,188.54
2.	22-03.0-107-018	HOME OFFICE	$ 5,288.24	$ 654.80
3.	22-.03.0-107-017	HOME OFFICE	$ 3,515.00	$ 435.23
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 20,991.78	$ 13,278.57

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	55			1998	$ 698,118	$ 17,866	39	$ 17,866	$	$ 257,292	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		12,038	9
10	CURTAIN TRACKS			1993	5,650	179	31.5	179		3,753	10
11	REWIRING WORK			1996	6,043	155	39	155		2,732	11
12	ROOF			1997	66,564	1,707	39	1,707		27,809	12
13	OUTDOOR FLOODLIGHTS			1997	2,856	73	39	73		1,171	13
14	HANDRAIL & WALL GUARDS			1999	2,524	64	39	64		953	14
15	STORAGE BARN			1999	2,100	55	39	55		776	15
16	BACKFLOW PREVENTER			2000	1,696	62	27.5	62		839	16
17	ROOF			2000	2,680	97	27.5	97		1,314	17
18	NEW WATER HEATER			2001	3,096	113	27.5	113		1,417	18
19	ALARM SYSTEM			2001	5,013	182	27.5	182		2,283	19
20	OVERBED LIGHT			2001	3,687	134	27.5	134		1,681	20
21	CARPET			2001	1,730		5			1,730	21
22	WATER HEATER TANK			2002	1,678	62	27.5	62		705	22
23	ALARM SYSTEM			2002	4,991	181	27.5	181		2,099	23
24	WATER HEATER			2003	2,846	103	27.5	103		1,087	24
25	WATER HEATER			2004	5,299	193	27.5	193		1,889	25
26	WINDOWS			2005	35,827	1,303	27.5	1,303		10,586	26
27	SMOKE DETECTORS			2005	1,754	64	27.5	64		547	27
28	STEEL FIRE DOOR			2005	1,974	72	27.5	72		615	28
29	FIRE SYSTEM			2005	1,769	64	27.5	64		546	29
30	CARPETING AND TILING			2006	13,437	489	27.5	489		3,809	30
31	WATER SOFTENER			2006	3,425	124	27.5	124		968	31
32	GENERATOR			2006	49,050	1,783	27.5	1,783		12,859	32
33	WATER HEATER			2007	5,007	182	27.5	182		1,191	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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DOORS	2009	$ 3,691	$ 134	27.5	$ 134	$	$ 654	37
38	FLOORING	2009	5,152	296	5	1,030	734	4,416	38
39	FLOORING	2009	2,809	162	5	562	400	2,410	39
40	MOULDINGS FOR DOORWAYS	2010	4,000	145	27.5	145		478	40
41									41
42	HOLDING TANK AND PIPING	2011	3,293	120	27.5	120		255	42
43									43
44	WATER HEATER	2012	5,805	211	27.5	211		413	44
45									45
46	SPRINKLER SYSTEM	2013	92,013	1,280	39	1,280		1,280	46
47	SHOWER ROOM	2013	6,354	88	39	88		88	47
48									48
49	KITCHEN HOOD	2013	2,325	332	7	332		332	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)		$ 1,104,499	$ 29,530		$ 30,664	$ 1,134	$ 363,015	70

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 39,227	$ 6	$ 3,923	$ 3,917	10	$ 35,698	71
72	Current Year Purchases	4,621	924	924		5	924	72
73	Fully Depreciated Assets	68,966					68,966	73
74								74
75	TOTALS	$ 112,814	$ 930	$ 4,847	$ 3,917		$ 105,588	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)	$ 1,307,793	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 30,460	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,511	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,051	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 468,603	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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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		$ 136,234			3
4	Additions							4
5								5
6								6
7	TOTAL		55		$ 136,234 **			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 [X] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

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

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 18,092 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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

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

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

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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 51,608	$		$ 51,608	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			24,033			24,033	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			58,984			58,984	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				55,758		55,758	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			$		$ 134,625	$ 55,758		$ 190,383	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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,895	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (45,000))	320,443		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,080		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deposit	13,750		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 347,168	$	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	361,799		15
16	Equipment, at Historical Cost	124,830		16
17	Accumulated Depreciation (book methods)	(215,743)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	20,495		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 291,381	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 638,549	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,463,665	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	125,000		29
30	Accrued Salaries Payable	45,073		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,677		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,189		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)**	$ 1,655,604	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Member Loans	1,406,583		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,406,583	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,062,187	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,423,638)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 638,549	$	48

***(See instructions.)**

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,106,996)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,106,996)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(316,642)	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)**	$ (316,642)	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)**	$ (2,423,638)	24	*

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,587,447	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,587,447	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	63,339	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 63,339	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***	824	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 824	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)**	$ 1,651,610	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	384,720	31
32	Health Care	773,155	32
33	General Administration	346,051	33
	B. Capital Expense		
34	Ownership	186,418	34
	C. Ancillary Expense		
35	Special Cost Centers	190,383	35
36	Provider Participation Fee	87,525	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,968,252	40
41	**Income before Income Taxes (line 30 minus line 40)****	(316,642)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (316,642)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 979,213	44
45	Private Pay - Net Inpatient Revenue	177,477	45
46	Medicare - Net Inpatient Revenue	433,094	46
47	Other-(specify) Insurance	(2,337)	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,587,447	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 NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,022	2,326	$ 59,276	$ 25.48	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,566	5,030	117,530	23.37	3
4	Licensed Practical Nurses	4,990	5,181	111,747	21.57	4
5	CNAs & Orderlies	22,847	25,350	248,164	9.79	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,851	2,219	29,615	13.35	8
9	Activity Director	628	831	9,716	11.69	9
10	Activity Assistants	1,604	1,826	15,775	8.64	10
11	Social Service Workers	1,709	2,041	25,912	12.70	11
12	Dietician					12
13	Food Service Supervisor	1,673	1,990	20,259	10.18	13
14	Head Cook	2,771	3,145	28,057	8.92	14
15	Cook Helpers/Assistants	5,892	6,641	60,694	9.14	15
16	Dishwashers					16
17	Maintenance Workers	1,852	2,103	22,923	10.90	17
18	Housekeepers	4,263	4,717	39,873	8.45	18
19	Laundry	1,896	2,023	19,088	9.44	19
20	Administrator	2,022	2,273	63,549	27.96	20
21	Assistant Administrator					21
22	Other Administrative	1,955	2,238	38,446	17.18	22
23	Office Manager	1,850	2,073	22,995	11.09	23
24	Clerical					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	1,912	2,211	21,164	9.57	31
32	Other Health C: MDS	1,748	2,043	48,158	23.57	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	68,051	76,261	$ 1,002,941 *	$ 13.15	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	96	$ 4,674	1-3	35
36	Medical Director	MONTHLY	18,000	9-3	36
37	Medical Records Consultant	24	1,560	10-3	37
38	Nurse Consultant	6	1,020	10-3	38
39	Pharmacist Consultant	MONTHLY	1,047	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	36	1,250	11-3	44
45	Social Service Consultant	36	1,250	12-3	45
46	Other(specify) PSYCHIATRIC	MONTHLY	6,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	198	$ 35,301		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	10	394	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	10	$ 394		53

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JULIE LOGAN	ADMINISTRATOR	0	$ 63,549
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,549

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		16,023
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 16,023

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,394
Unemployment Compensation Insurance	36,994
FICA Taxes	82,134
Employee Health Insurance	20,133
Employee Meals	6,011
Illinois Municipal Retirement Fund (IMRF)*	
401K	1,174
PENSION	3,958
TOTAL (agree to Schedule V, line 22, col.8)	$ 169,798

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

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	1,060
Health Care Worker Background Check	515
(Indicate # of checks performed 28)	
Patient Background Checks 60	1,568
SEE ATTACHED SCHEDULE	6,808
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,941

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Corp Nurse Consultant	2,219
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,219

**See instructions.

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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 $3036**

(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? **5-10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(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. $ **87,525**
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. $ **6,011** 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? **25**
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? **N/A**
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 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? **N/A**
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 12/31/13

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

TOTAL FOOD PURCHASE	$ 58,351
LESS SALES TAX	$ 584
NET FOOD	$ 57,767
TOTAL PATIENT CENSUS	10,475
MEALS PER DAY	3
TOTAL PATIENT MEALS	31,425
EMPLOYEES MEALS PER DAY	10
DAYS PER YEAR	365
TOTAL EMPLOYEE MEALS	3,650
TOTAL MEALS PER YEAR	35,075
COST PER MEAL	$ 1.65
TOTAL EMPLOYEE MEAL COST	$ 6,011

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/13

SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
CONCENTRATORS	$ 1,411
BEDS	$ 5,276
IV PUMPS	$ 1,411
DISHWASHER	$ 802
BEVERAGE EQUIP	$ 288
POSTAGE MACHINE	$ 214
COPIER	$ 442
BATH SYSTEM	$ 3,012
WOUND CARE MACHINE	$ 1,665
WASHING MACHINE	$ 615
STORAGE UNIT	$ 245
SINK MACHINE	$ 144
SEWER MACHINE	$ 155
COMPUTERS	$ 319
COPIER	$ 1,778
STORAGE UNIT	$ 315
TOTAL	$ 18,092

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/13

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	AMOUNT
SIKICH	ACCTG SVC	9,478
COLE TAYLOR	LEGAL FEES	694
IIT SOURCETECH	IT	1,598
ILLINI TECH	WEBSITE DOMAIN RENEWAL	70
SMARTLINX SOLUTIONS	PAYROLL SOFTWARE	249
MARGEL PEDDICORD	CONSULT MEDICAID CAP RATE	520
TOTALS		12,610
TALX Corp	Tax Credit	452
Kalin Healthcare Solutions	Nursing/MDS Consultant	296
Benefit Planning Consult	401K Third Party Admin	194
IHD Corp	Interviewing/Supervising	113
Dun & Bradstreet	Credit Rating	617
Sandberg Phoenix & Von Gontard	Legal Services	88
Stratton, Giganti, Stone, & Kopec	Legal Services	1,000
Duane Morris LLP	Legal Services	343
Sikich	Accounting	145
Cole Taylor	Loan Recording	42
Sikich	Accounting	124
		3,414
		16,023

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/13

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	AMOUNT
IHCA	DUES	$ 3,036
EHEALTH	CAREWATCH	$ 2,046
WHITESIDE COUNTY	FOOD PERMIT	$ 190
FIRE MARSHALL	PREMIT	$ 100
SEC OF STATE	VEHICLE LIC	$ 258
NGS	MEDICARE FEE	$ 532
CITY ROCK FALLS	BLDG PERMIT	$ 34
SAUK VALLEY NEWS	SUBCRIPTION	$ 224
TOTALS		$ 6,420

AICPA Member Services	Dues	$ 54
Medpass Inc.	Subscription	$ 40
MES of Illinois Inc	Dues	$ 48
Sangamo Club	Dues	$ 157
American Express	Membership	$ 12
Illinois Nursing Home Assoc	Dues	$ 10
Illinois CPA Society	Dues	$ 39
Wall-St Journal	Subscription	$ 29
		$ 388
Total		$ 6,808

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/13

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	AMOUNT
TRANSPORT VAN	$ 5,440
Amber Kobler	$ 737
Beth Johnson-Peppers	$ 289
Bridgette Elder	$ 86
Crystal Kelchner	$ 57
Harold Blanton	$ 452
Julie Logan	$ 1,580
Kim Shuman	$ 190
Lacey Rus	$ 69
Laurie Full	$ 82
Lisa Trader	$ 11
Mandi Weed	$ 186
TOTALS	$ 9,179

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 12/31/13

Reclassification Detail

Vendor	Type	GL	Dr	Cr	Line #
T6	Internet	18360	98.49		21
		18160		98.49	19
IIT/SOURCETECH	Dietary software	18160	335.00		19
		17105		335.00	1
C&K MINI STORAGE	Storage Unit	19640	245.00		35
		16110		245.00	35
PERFORMANCE FOODSERVICE	Water softener pellets	16111	1,596.16		6
		16110		1,596.16	35
ACRES	Soda	15572	35.23		11
		16110		35.23	35
MAILWAUKEE MAILING	Postage Machine Ink	18280	154.09		21
		18190		154.09	35

Summary

Line 21	252.58
Line 19	236.51
Line 1	-335.00
Line 35	-1785.48
Line 6	1596.16
Line 11	35.23
Total	0

TRANSITIONS NURSING AND REHAB CENTRE INC
FACILITY ID 0035642
SCHEDULE VII
C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
REPORT PERIOD ENDING 12/31/2013

FACILITY ID	0046417	0046250	0046235	0035659	
	EVERGREEN	DOUGLAS	DOCTORS	TAMMERLANE	TOTAL
NAME	NURSING AND REHAB	NURSING AND REHAB	NURSING AND REHAB	HEALTHCARE CENTRE	OTHER
ROBERT HEDGES	$ 55,544	$ 26,613	$ 51,398	$ 41,066	$ 174,621
WILLIAM IRVINE	$ 53,274	$ 25,525	$ 49,298	$ 39,387	$ 167,484
MARTHA IRVINE	$ 4,151	$ 1,989	$ 3,841	$ 3,069	$ 13,050
DEREK HEDGES	$ 26,801	$ 12,841	$ 24,801	$ 19,815	$ 84,258
	$ 139,770	$ 66,968	$ 129,338	$ 103,337	$ 439,413