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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

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 1/1/2014 to 10/31/2014 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: 1/1/2014 Ending: 10/31/2014

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	16,720	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	16,720	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	971	26	1,088	2,085	8
9	SNF/PED					9
10	ICF	6,211	953		7,164	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,182	979	1,088	9,249	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.32%

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 1,088

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: 12/31/2014 Fiscal Year: 12/31/2014

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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	102,318	5,487	3,799	111,604		111,604		111,604			1
2	Food Purchase		54,254		54,254	(6,244)	48,010	16	48,026			2
3	Housekeeping	25,552	7,249		32,801		32,801		32,801			3
4	Laundry	32,585	3,631		36,216		36,216		36,216			4
5	Heat and Other Utilities			68,742	68,742		68,742	(3,896)	64,846			5
6	Maintenance	23,723	7,970	22,146	53,839		53,839	860	54,699			6
7	Other (specify):* SCAVENGER			13,434	13,434		13,434		13,434			7
8	TOTAL General Services	184,178	78,591	108,121	370,890	(6,244)	364,646	(3,020)	361,626			8
	B. Health Care and Programs											
9	Medical Director			15,000	15,000		15,000		15,000			9
10	Nursing and Medical Records	588,867	27,997	10,508	627,372		627,372		627,372			10
10a	Therapy	30,044			30,044		30,044		30,044			10a
11	Activities	28,474	72	1,000	29,546		29,546		29,546			11
12	Social Services	26,807		1,000	27,807		27,807		27,807			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	674,192	28,069	27,508	729,769		729,769		729,769			16
	C. General Administration											
17	Administrative	61,906			61,906		61,906	61,552	123,458			17
18	Directors Fees											18
19	Professional Services			24,114	24,114		24,114	(3,356)	20,758			19
20	Dues, Fees, Subscriptions & Promotions			21,066	21,066		21,066	(10,518)	10,548			20
21	Clerical & General Office Expenses	50,785	6,739	25,523	83,047		83,047	(24,506)	58,541			21
22	Employee Benefits & Payroll Taxes			98,217	98,217	6,244	104,461	16,114	120,575			22
23	Inservice Training & Education			2,242	2,242		2,242	230	2,472			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,528	9,528		9,528	(2,108)	7,420			25
26	Insurance-Prop.Liab.Malpractice			20,517	20,517		20,517	710	21,227			26
27	Other (specify):*			126,653	126,653		126,653	(126,653)				27
28	TOTAL General Administration	112,691	6,739	327,860	447,290	6,244	453,534	(88,535)	364,999			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	971,061	113,399	463,489	1,547,949		1,547,949	(91,555)	1,456,394			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: 1/1/2014 Ending: 10/31/2014

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			13,519	13,519		13,519	23,571	37,090			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			6,047	6,047		6,047	67,884	73,931			32
33	Real Estate Taxes			10,206	10,206		10,206	976	11,182			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			17,264	17,264		17,264		17,264			35
36	Other (specify):*											36
37	**TOTAL Ownership**			47,036	47,036		47,036	92,431	139,467			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		41,009	108,730	149,739		149,739		149,739			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			74,624	74,624		74,624		74,624			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		41,009	183,354	224,363		224,363		224,363			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	971,061	154,408	693,879	1,819,348		1,819,348	876	1,820,224			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: 1/1/2014 Ending: 10/31/2014

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	(4,889)	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	4,892	30		9
10	Interest and Other Investment Income	(456)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(543)	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	(198)	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	(125,945)	27		24
25	Fund Raising, Advertising and Promotional	(9,920)	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	(39,804)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (176,863)		$	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)	177,739		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 177,739		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 876		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: 1/1/2014

Ending: 10/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	MARKETING SALARY	$ (30,133)	21	1
2	SPECIAL EVENTS	(510)	27	2
3	EMPLOYEE MEAL RECEIPTS	559	2	3
4	NON INCLUDABLE DUES AND SUBSCRIPTION	(809)	20	4
5	NON INCLUDABLE LEGAL FEES	(5,466)	19	5
6	MARKETING TRAVEL	(3,445)	25	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(39,804)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 **Report Period Beginning:** 1/1/2014 **Ending:** 10/31/2014

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	16	0	0	0	0	0	0	0	0	0	0	16	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	(4,889)	993	0	0	0	0	0	0	0	0	0	(3,896)	5
6	Maintenance	0	860	0	0	0	0	0	0	0	0	0	860	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,873)	1,853	0	0	0	0	0	0	0	0	0	(3,020)	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	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	61,552	0	0	0	0	0	0	0	0	0	61,552	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(5,466)	1,672	438	0	0	0	0	0	0	0	0	(3,356)	19
20	Fees, Subscriptions & Promotions	(10,729)	211	0	0	0	0	0	0	0	0	0	(10,518)	20
21	Clerical & General Office Expenses	(30,133)	5,482	145	0	0	0	0	0	0	0	0	(24,506)	21
22	Employee Benefits & Payroll Taxes	0	16,114	0	0	0	0	0	0	0	0	0	16,114	22
23	Inservice Training & Education	0	230	0	0	0	0	0	0	0	0	0	230	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(3,445)	1,337	0	0	0	0	0	0	0	0	0	(2,108)	25
26	Insurance-Prop.Liab.Malpractice	0	710	0	0	0	0	0	0	0	0	0	710	26
27	Other (specify):*	(126,653)	0	0	0	0	0	0	0	0	0	0	(126,653)	27
28	**TOTAL General Administration**	(176,426)	87,308	583	0	0	0	0	0	0	0	0	(88,535)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(181,299)	89,161	583	0	0	0	0	0	0	0	0	(91,555)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 **Report Period Beginning:** 1/1/2014 **Ending:** 10/31/2014

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	4,892	0	785	17,894	0	0	0	0	0	0	0	23,571	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(456)	0	936	67,404	0	0	0	0	0	0	0	67,884	32
33	Real Estate Taxes	0	0	976	0	0	0	0	0	0	0	0	976	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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**	4,436	0	2,697	85,298	0	0	0	0	0	0	0	92,431	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)**	(176,863)	89,161	3,280	85,298	0	0	0	0	0	0	0	876	45

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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		$ 860	$ 860	1
2	V	5	UTILITIES		HI CARE MANAGEMENT		993	993	2
3	V	10	NURSING		HI CARE MANAGEMENT				3
4	V	17	ADMINISTRATION		HI CARE MANAGEMENT		61,552	61,552	4
5	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		5,482	5,482	5
6	V	19	PROFESSIONAL SERVICES		HI CARE MANAGEMENT		1,672	1,672	6
7	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		211	211	7
8	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		230	230	8
9	V	25	TRAVEL		HI CARE MANAGEMENT		1,337	1,337	9
10	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		710	710	10
11	V	22	PAYROLL TAX ABD BENEFITS		HI CARE MANAGEMENT		16,114	16,114	11
12	V								12
13	V								13
14	Total			$			$ 89,161	$ * 89,161	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: 1/1/2014 Ending: 10/31/2014

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)		$ 785	$ 785	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		936	936	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		976	976	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES (HOME OFFICE)		438	438	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		145	145	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			$			$ 3,280	$ * 3,280	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: 1/1/2014 Ending: 10/31/2014

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	$	H&I PROPERTIES (FACILITY)		$	$	15
16	V	30	DEPRECIATION		H&I PROPERTIES (FACILITY)		17,894	17,894	16
17	V	32	INTEREST		H&I PROPERTIES (FACILITY)		67,404	67,404	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			$			$ 85,298	$ * 85,298	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: 1/1/2014 Ending: 10/31/2014

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	137,365	3.564	0.09		$ 13,437	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50	129,516	3.564	0.09		12,669	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	13,159	3.564	0.09		1,287	17-7	3
4	DEREK HEDGES	VP OPERATIONS	VP OPERATIONS	0.00	86,962	3.564	0.09		8,507	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 35,900		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: 1/1/2014 Ending: 0/31/2014

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	103,802	5	$ 9,651	$ 4,449	9,249	$ 860	1
2	5	UTILITIES	PER RESIDENT DAY	103,802	5	11,142		9,249	993	2
3	10	NURSING	PER RESIDENT DAY	103,802	5			9,249	0	3
4	17	ADMINISTRATION	PER RESIDENT DAY	103,802	5	690,800	690,800	9,249	61,552	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	103,802	5	61,526		9,249	5,482	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	103,802	5	18,760		9,249	1,672	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	103,802	5	2,373		9,249	211	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	103,802	5	2,580		9,249	230	8
9	25	TRAVEL	PER RESIDENT DAY	103,802	5	15,007		9,249	1,337	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	103,802	5	7,969		9,249	710	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	103,802	5	180,848		9,249	16,114	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					$ 1,000,656	$ 695,249		$ 89,161	25

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 0/31/2014

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	423	5	$ 7,214	$	46	$ 785	1
2	32	INTEREST	PER LICENSE BED	423	5	8,604		46	936	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	423	5	8,975		46	976	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	423	5	4,030		46	438	4
5	21	OFFICE EXPENSE	PER LICENSE BED	423	5	1,329		46	145	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					$ 30,152	$		$ 3,280	25

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 0/31/2014

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	$ 17,894	$	1	$ 17,894	1
2	32	INTEREST	DIRECT	1	1	67,404		1	67,404	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					$ 85,298	$		$ 85,298	25

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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	$	08/15/2015	0.0650	$ 67,404	1
2	US BANK (HI PROP)		X	MORTGAGE (HOME OFFC)		6/29/2005			06/29/2017	0.0425	936	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR BANK		X	WORKING CAPITAL	INTEREST	REVOLV			REVOLV	PRIME +	6,047	6
7												7
8												8
9	TOTAL Facility Related				$10,729.00		$ 1,410,500	$			$ 74,387	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	$			$ 74,387	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: 1/1/2014 Ending: 10/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 13,004	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.)		$ 13,191	2
3. Under or (over) accrual (line 2 minus line 1).		$ 187	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,995	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.		$ 11,182	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	10,763	8
	2010	13,229	9
	2011	13,427	10
	2012	13,279	11
	2013	13,191	12

Tax for 1/1 thru 10/31

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-27-401-002	NURSING HOME	$ 12,215.18	$ 12,215.18
2.	22-03.0-107-018	HOME OFFICE	$ 5,391.38	$ 586.30
3.	22-.03.0-107-017	HOME OFFICE	$ 3,583.56	$ 389.70
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 21,190.12	$ 13,191.18

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 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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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: 1/1/2014 Ending: 10/31/2014

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: 1/1/2014 Ending: 10/31/2014

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	$	$ 275,186	4
5											5
6	H&I										6
7	PROP										7
8	OFFC BLD			2005	32,566	785	39	785			8
	Improvement Type**										
9	PARKING LOT IMPROVEMENTS			1992	17,677	561	31.5	561		12,599	9
10	CURTAIN TRACKS			1993	5,650	179	31.5	179		3,932	10
11	REWIRING WORK			1996	6,043	155	39	155		2,887	11
12	ROOF			1997	66,564	1,707	39	1,707		29,516	12
13	OUTDOOR FLOODLIGHTS			1997	2,856	73	39	73		1,244	13
14	HANDRAIL & WALL GUARDS			1999	2,524	64	39	64		1,017	14
15	STORAGE BARN			1999	2,100	55	39	55		831	15
16	BACKFLOW PREVENTER			2000	1,696	62	27.5	62		901	16
17	ROOF			2000	2,680	97	27.5	97		1,411	17
18	NEW WATER HEATER			2001	3,096	113	27.5	113		1,530	18
19	ALARM SYSTEM			2001	5,013	182	27.5	182		2,465	19
20	OVERBED LIGHT			2001	3,687	134	27.5	134		1,815	20
21	CARPET			2001	1,730		5			1,730	21
22	WATER HEATER TANK			2002	1,678	61	27.5	61		766	22
23	ALARM SYSTEM			2002	4,991	181	27.5	181		2,280	23
24	WATER HEATER			2003	2,846	104	27.5	104		1,191	24
25	WATER HEATER			2004	5,299	193	27.5	193		2,082	25
26	WINDOWS			2005	35,827	1,303	27.5	1,303		11,889	26
27	SMOKE DETECTORS			2005	1,754	64	27.5	64		611	27
28	STEEL FIRE DOOR			2005	1,974	72	27.5	72		687	28
29	FIRE SYSTEM			2005	1,769	64	27.5	64		610	29
30	CARPETING AND TILING			2006	13,437	489	27.5	489		4,298	30
31	WATER SOFTENER			2006	3,425	124	27.5	124		1,092	31
32	GENERATOR			2006	49,050	1,783	27.5	1,783		14,642	32
33	WATER HEATER			2007	5,007	182	27.5	182		1,373	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: 1/1/2014 Ending: 10/31/2014

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	$	$ 788	37
38	FLOORING	2009	5,152	148	5	1,030	882	4,564	38
39	FLOORING	2009	2,809	81	5	562	481	2,491	39
40	MOULDINGS FOR DOORWAYS	2010	4,000	145	27.5	145		623	40
41									41
42	HOLDING TANK AND PIPING	2011	3,293	120	27.5	120		375	42
43									43
44	WATER HEATER	2012	5,805	211	27.5	211		624	44
45									45
46	SPRINKLER SYSTEM	2013	92,013	2,359	39	2,359		3,639	46
47	SHOWER ROOM	2013	6,354	163	39	163		251	47
48									48
49	KITCHEN HOOD	2013	2,325	569	7	569		901	49
50									50
51	BOILER TUBES	2014	5,300	108	39	108		108	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)		$ 1,109,799	$ 30,719		$ 32,082	$ 1,363	$ 392,949	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: 1/1/2014 Ending: 10/31/2014

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	$ 43,848	$ 1,479	$ 5,008	$ 3,529		$ 41,630	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	68,966					68,966	73
74								74
75	TOTALS	$ 112,814	$ 1,479	$ 5,008	$ 3,529		$ 110,596	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)	$ 1,313,093	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,198	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,090	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 4,892	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 503,545	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: 1/1/2014 Ending: 10/31/2014

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		$ 0			3
4	Additions							4
5								5
6								6
7	TOTAL		55		$ **			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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 17,264 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: 1/1/2014 Ending: 10/31/2014

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: 1/1/2014 Ending: 10/31/2014

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	$		$ 44,981	$		$ 44,981	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			13,209			13,209	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			50,540			50,540	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				41,009		41,009	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			$		$ 108,730	$ 41,009		$ 149,739	14

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

STATE OF ILLINOIS

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/2014 (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	$ 19,534	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 45,000)	3,354		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,343		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)**	$ 26,231	$	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	367,099		15
16	Equipment, at Historical Cost	124,830		16
17	Accumulated Depreciation (book methods)	(229,262)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	15,060		21
22	Other Long-Term Assets (spe Insur Deposit	13,750		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 291,477	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 317,708	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 52,454	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	1,912		31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,179		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Medicaid Advance	59,735		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 124,280	$	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	1,506,583		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,506,583	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,630,863	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,313,155)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 317,708	$	48

***(See instructions.)**

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,423,638)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,423,638)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(233,637)	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) **Writeoff of intercompany payable**	1,344,120	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,110,483	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,313,155)	24 *

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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	$ 1,554,951	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,554,951	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	30,304	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 30,304	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***	456	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 456	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)**	$ 1,585,711	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	364,646	31
32	Health Care	729,769	32
33	General Administration	453,534	33
	B. Capital Expense		
34	Ownership	47,036	34
	C. Ancillary Expense		
35	Special Cost Centers	149,739	35
36	Provider Participation Fee	74,624	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,819,348	40
41	**Income before Income Taxes (line 30 minus line 40)****	(233,637)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (233,637)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 970,822	44
45	Private Pay - Net Inpatient Revenue	131,349	45
46	Medicare - Net Inpatient Revenue	452,780	46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 1,554,951	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: 1/1/2014 Ending: 10/31/2014

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,748	2,166	$ 56,969	$ 26.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,103	3,579	83,932	23.45	3
4	Licensed Practical Nurses	6,436	7,143	151,454	21.20	4
5	CNAs & Orderlies	20,586	24,108	232,458	9.64	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,586	2,262	30,044	13.28	8
9	Activity Director	1,631	1,943	18,487	9.51	9
10	Activity Assistants	1,124	1,246	9,987	8.02	10
11	Social Service Workers	1,497	2,213	26,807	12.11	11
12	Dietician					12
13	Food Service Supervisor	1,651	1,997	19,548	9.79	13
14	Head Cook	2,492	3,096	26,336	8.51	14
15	Cook Helpers/Assistants	5,053	6,291	56,434	8.97	15
16	Dishwashers					16
17	Maintenance Workers	1,788	2,240	23,723	10.59	17
18	Housekeepers	2,247	2,937	25,552	8.70	18
19	Laundry	3,725	4,069	32,585	8.01	19
20	Administrator	1,756	2,099	61,906	29.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,564	1,823	20,652	11.33	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	1,145	1,392	12,646	9.08	31
32	Other Health C: MDS	1,584	2,267	51,408	22.68	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	60,716	72,871	$ 940,928 *	$ 12.91	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	88	$ 3,799	1-3	35
36	Medical Director	MONTHLY	15,000	9-3	36
37	Medical Records Consultant	18	780	10-3	37
38	Nurse Consultant			10-3	38
39	Pharmacist Consultant	MONTHLY	894	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	5	1,000	11-3	44
45	Social Service Consultant	5	1,000	12-3	45
46	Other(specify) PSYCHIATRIC	MONTHLY	4,500	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	$ 26,973		49

C. CONTRACT NURSES

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

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JULIE LOGAN	ADMINISTRATOR	0	$ 61,906
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,906

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		20,758
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 20,758

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,475
Unemployment Compensation Insurance	33,344
FICA Taxes	78,523
Employee Health Insurance	11,849
Employee Meals	6,244
Illinois Municipal Retirement Fund (IMRF)*	
401K	2,043
PENSION	4,460
SCREENING	399
ACCRUED BENEFITS PAID REVERSAL	(37,762)
TOTAL (agree to Schedule V, line 22, col.8)	$ 120,575

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	$ 3,980
Advertising: Employee Recruitment	617
Health Care Worker Background Check	432
(Indicate # of checks performed 28)	
Patient Background Checks 39	840
SEE ATTACHED SCHEDULE	4,679
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,548

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number TRANSITIONS NSG & REHAB CTR # 0035642 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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: 1/1/2014 Ending: 10/31/2014

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $2530**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **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. $ **74,624**
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. $ 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? **NA**
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) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
COST REPORT PERIOD ENDING 10/31/14

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

TOTAL FOOD PURCHASE	$ 54,254
LESS SALES TAX	$ 543
NET FOOD	$ 53,711
TOTAL PATIENT CENSUS	9,249
MEALS PER DAY	3
TOTAL PATIENT MEALS	27,747
EMPLOYEES MEALS PER DAY	10
DAYS PER YEAR	365
TOTAL EMPLOYEE MEALS	3,650
TOTAL MEALS PER YEAR	31,397
COST PER MEAL	$ 1.71
TOTAL EMPLOYEE MEAL COST	$ 6,244

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
COST REPORT PERIOD ENDING 10/31/14

SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
CONCENTRATORS	$ 1,615
BEDS	$ 1,514
IV PUMPS	$ 750
DISHWASHER	$ 119
BEVERAGE EQUIP	$ 240
POSTAGE MACHINE	$ 228
COPIER	$ 1,584
BATH SYSTEM	$ 3,898
WOUND CARE MACHINE	$ 5,773
WASHING MACHINE	$ 502
STORAGE UNIT	$ 585
COMPUTERS	$ 456
TOTAL	$ 17,264

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
COST REPORT PERIOD ENDING 10/31/14

SCHEDULE XIX (C) PROFESSIONAL SERVICES

VENDOR	TYPE	AMOUNT
SIKICH	ACCTG SVC	10,486
MDI	IT SERVICES	3,958
IIT SOURCETECH	IT	1,388
TALX	UNEMPLOYMENT SVCS	611
E SOLUTIONS	IT SERVICES	673
SMARTLINX SOLUTIONS	PAYROLL SOFTWARE	2,173
MB FINANCIAL	FIN SERVICES	438
BILL RADKEY	LEGAL	708
BPC	PROF FEES	128
WAGE WORKS	PAYROLL FEES	33
KBA	INSURANCE FEES	89
CT CORP	CORP FEES	5
D&B	CREDIT FEES	68
TOTALS		20,758

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
COST REPORT PERIOD ENDING 10/31/14

SCHEDULE XIX (F) DUES FEES SUBSCRIPTIONS AND PROMOTIONS

VENDOR	TYPE	AMOUNT
IHCA	DUES	$ 2,530
EHEALTH	CAREWATCH	$ 1,194
CLIA LAB	PERMIT	$ 150
SEC OF STATE	VEHICLE LIC	$ 258
HPSI	DUES	$ 100
SAUK VALLEY NEWS	SUBCRIPTION	$ 236
WSJ	SUBSCRIPTION	$ 48
MED PASS	SUBSCRIPTION	$ 37
SHRM	DUES	$ 16
ICPAS	DUES	$ 37
AICPA	DUES	$ 37
INHA	DUES	$ 9
INHA ADMINISTRATOR	DUES	$ 27
TOTALS		$ 4,679

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULES
COST REPORT PERIOD ENDING 10/31/14

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	AMOUNT
TRANSPORT VAN	$ 3,922
Amber Kobler	$ 153
Beth Johnson-Peppers	$ 76
Harold Blanton	$ 494
Julie Logan	$ 1,093
Kim Shuman	$ 70
Carol Fuller	$ 100
Glen Wicks	$ 175
Corporate Staff	$ 1,337
TOTALS	$ 7,420

TRANSITIONS NURSING AND REHAB CENTRE
FACILITY ID 0035642
SCHEDULE VII
C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
COST REPORT PERIOD ENDING 10/31/14

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	$ 47,051	$ 20,346	$ 41,880	$ 28,088	$ 137,365
WILLIAM IRVINE	$ 44,363	$ 19,184	$ 39,486	$ 26,483	$ 129,516
MARTHA IRVINE	$ 4,507	$ 1,949	$ 4,012	$ 2,691	$ 13,159
DEREK HEDGES	$ 29,787	$ 12,881	$ 26,512	$ 17,782	$ 86,962
	$ 125,708	$ 54,360	$ 111,890	$ 75,044	$ 367,002