

		FOR BHF USE					

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2009
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2009)

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.

<p>I. IDPH License ID Number: <u>0035642</u></p> <p>Facility Name: <u>TRANSITIONS NURSING & REHAB CENTER</u></p> <p>Address: <u>1000 DIXON AVENUE</u> <u>ROCK FALLS</u> <u>61071</u> Number City Zip Code</p> <p>County: <u>WHITESIDE</u></p> <p>Telephone Number: <u>(815) 625-8510</u> Fax # <u>(815) 625-8443</u></p> <p>HFS ID Number: <u>36-3651790</u></p> <p>Date of Initial License for Current Owners: <u>07/01/89</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>BOB KAGDA</u> Telephone Number: <u>(847) 675-3585</u> Email Address: _____</p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2009</u> to <u>12/31/2009</u> 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.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td rowspan="2" style="width: 15%;">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____</td> </tr> <tr> <td></td> <td>(Title) <u>PRESIDENT</u></td> </tr> <tr> <td rowspan="4" style="width: 15%;">Paid Preparer</td> <td>(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u></td> </tr> <tr> <td>(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u></td> </tr> <tr> <td></td> <td>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</td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Type or Print Name) <u>ROBERT HEDGES</u> (Date) _____		(Title) <u>PRESIDENT</u>	Paid Preparer	(Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u>	(Date) _____	(Print Name and Title) <u>BOB KAGDA</u> <u>VICE PRESIDENT</u>	(Firm Name & Address) <u>KRUPNICK, BOKOR, KAGDA & BROOKS, LTD</u> <u>3750 W DEVON, LINCOLNWOOD, IL 60712-1124</u>		(Telephone) <u>(847) 675-3585</u> Fax # <u>(847) 675-5777</u>		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
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Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER

0035642 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	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				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	1,817	264	931	3,012	8
9	SNF/PED					9
10	ICF	9,920	1,319		11,239	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,737	1,583	931	14,251	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.99%

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 07/01/89

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

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 55 and days of care provided 931

Medicare Intermediary NATIONAL GOVERNMENT SERVICES

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

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

Facility Name & ID Number **TRANSITIONS NURSING & REHAB CEN1** # **0035642** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	110,883	4,623	6,414	121,920		121,920		121,920		1
2	Food Purchase		70,840		70,840	(3,438)	67,402	(99)	67,303		2
3	Housekeeping	63,244	8,535		71,779		71,779		71,779		3
4	Laundry	30,888	4,099	198	35,185		35,185		35,185		4
5	Heat and Other Utilities			70,772	70,772		70,772	761	71,533		5
6	Maintenance	27,443	4,170	17,225	48,838		48,838	4,518	53,356		6
7	Other (specify):*			5,429	5,429		5,429	118	5,547		7
8	TOTAL General Services	232,458	92,267	100,038	424,763	(3,438)	421,325	5,298	426,623		8
	B. Health Care and Programs										
9	Medical Director			24,375	24,375		24,375		24,375		9
10	Nursing and Medical Records	737,278	43,082	8,812	789,172		789,172	(3,600)	785,572		10
10a	Therapy	28,908	56	55	29,019		29,019		29,019		10a
11	Activities	49,803	717		50,520		50,520		50,520		11
12	Social Services	26,911		2,810	29,721		29,721		29,721		12
13	CNA Training										13
14	Program Transportation			453	453		453		453		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	842,900	43,855	36,505	923,260		923,260	(3,600)	919,660		16
	C. General Administration										
17	Administrative	57,361			57,361		57,361	58,284	115,645		17
18	Directors Fees										18
19	Professional Services			40,026	40,026		40,026	1,998	42,024		19
20	Dues, Fees, Subscriptions & Promotions			18,277	18,277		18,277	(9,290)	8,987		20
21	Clerical & General Office Expenses	56,487	5,258	55,960	117,705		117,705	(30,698)	87,007		21
22	Employee Benefits & Payroll Taxes			149,001	149,001	3,438	152,439		152,439		22
23	Inservice Training & Education										23
24	Travel and Seminar			4,516	4,516		4,516	551	5,067		24
25	Other Admin. Staff Transportation			12,996	12,996		12,996	(5,663)	7,333		25
26	Insurance-Prop.Liab.Malpractice			33,014	33,014		33,014	1,918	34,932		26
27	Other (specify):*			11,789	11,789		11,789	5,011	16,800		27
28	TOTAL General Administration	113,848	5,258	325,579	444,685	3,438	448,123	22,111	470,234		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,189,206	141,380	462,122	1,792,708		1,792,708	23,809	1,816,517		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.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	6,414
	REPAIRS & MAINTENANCE	0
		0
		6,414
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	198
		0
		198
5	HEAT & OTHER UTILITIES	
	GAS HEAT	20,348
	ELECTRICITY	18,387
	WATER	27,788
	CABLE TV - LOBBY	4,249
		0
		70,772
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,610
	PAINTING & DECORATING	811
	BUILDING REPAIRS	3,831
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	6,176
	ELEVATOR MAINTENANCE & REPAIR	0
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	940
	FIRE SERVICE	3,857
		0
		0
		0
		0
		17,225
7	OTHER	
	SCAVENGER	5,429
	SECURITY SERVICE	0
		0
		0
		5,429
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	24,375
		24,375

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	3,228
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	1,170
	PHARMACY CONSULTANT XVIII B 39-2	814
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	3,600
		0
		0
		8,812
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	55
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		55
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	610
	SOCIAL WORKER XVIII B 45-2	2,200
		0
		2,810
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	453
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	0
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	13,742
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	26,284
		0
		40,026
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	6,350
	EMPLOYEE WANT ADS XIX F	1,653
	CONTRIBUTIONS VI 20 XIX F	50
	DUES & SUBSCRIPTIONS XIX F	3,925
	LICENSES & PERMITS XIX F	1,528
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	1,765
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	1,877
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	709
	PATIENT BACKGROUND CHECKS XIX F	420
		18,277
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	8,317
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	27,755
	HOME OFFICE EXPENSE	12,000
	THEFT & DAMAGE LOSS	0
	TELEPHONE	7,888
	MESSENGER SERVICE	0
		0
		55,960

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	90,974
	UNEMPLOYMENT COMPENSATION XIX D	14,816
	WORKERS COMPENSATION INSURANC XIX D	32,665
	HOSPITALIZATION INSURANCE XIX D	1,289
	EMPLOYEE BENEFITS - OTHER XIX D	9,114
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	143
	CHICAGO HEAD TAX XIX D	0
		0
		149,001
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	4,516
	TRAVEL XIX G	0
		4,516
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	12,996
		12,996
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	33,014
		33,014
27	OTHER	
	BAD DEBTS VI 24	11,298
	BAD DEBTS-OTHER	491
		11,789

GRAND TOTAL COLUMN 3 OTHER

462,122

**TRANSITIONS NURSING & REHAB CENTER
SCHEDULES
12/31/2009**

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

TOTAL FOOD PURCHASE	70,840
LESS SALES TAX	<u>(99)</u>
NET FOOD	70,741
TOTAL PATIENT CENSUS	14,251
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	42,753
ADD # EMPLOYEE MEALS/DAY	6
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	2,190
PATIENT MEALS	42,753
ADD EMPLOYEE MEALS	<u>2,190</u>
TOTAL MEALS/YEAR	44,943
NET FOOD	70,741
DIVIDE TOTAL MEALS/YEAR	<u>44,943</u>
COST PER MEAL	1.57
TIME EMPLOYEE MEALS	<u>2,190</u>
EMPLOYEE MEAL RECLASSIFICATION	3,438
	=====

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER #0035642 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			17,112	17,112		17,112	18,472	35,584			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,247	15,247		15,247	92,538	107,785			32
33	Real Estate Taxes			5,479	5,479		5,479	955	6,434			33
34	Rent-Facility & Grounds			138,188	138,188		138,188	(138,188)				34
35	Rent-Equipment & Vehicles			12,143	12,143		12,143		12,143			35
36	Other (specify):*											36
37	TOTAL Ownership			188,169	188,169		188,169	(26,223)	161,946			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,983	109,873	145,856		145,856		145,856			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,113	30,113		30,113		30,113			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		35,983	139,986	175,969		175,969		175,969			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,189,206	177,363	790,277	2,156,846		2,156,846	(2,414)	2,154,432			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS
TRANSITIONS NURSING & REHAB CENTER

ID# 0035642

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2	MARKETING SALARY	(14,579)	21	2
3	PROF FEES-HEALTHCARE HORIZON	(6,000)	21	3
4	STAFF TRANSPORTATION - MARKETING	(7,074)	25	4
5	HEALTHCARE HORIZONS	(3,600)	10	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(31,253)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER# 0035642

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(99)	0	0	0	0	0	0	0	0	0	0	(99)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	761	0	0	0	0	0	0	0	0	0	761	5
6	Maintenance	0	4,518	0	0	0	0	0	0	0	0	0	4,518	6
7	Other (specify):*	0	118	0	0	0	0	0	0	0	0	0	118	7
8	TOTAL General Services	(99)	5,397	0	5,298	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	(3,600)	0	0	0	0	0	0	0	0	0	0	(3,600)	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	(3,600)	0	0	0	0	0	0	0	0	0	0	(3,600)	16
	C. General Administration													
17	Administrative	0	58,284	0	0	0	0	0	0	0	0	0	58,284	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,998	0	0	0	0	0	0	0	0	0	1,998	19
20	Fees, Subscriptions & Promotions	(10,042)	752	0	0	0	0	0	0	0	0	0	(9,290)	20
21	Clerical & General Office Expenses	(48,334)	17,636	0	0	0	0	0	0	0	0	0	(30,698)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	551	0	0	0	0	0	0	0	0	0	551	24
25	Other Admin. Staff Transportation	(7,074)	1,411	0	0	0	0	0	0	0	0	0	(5,663)	25
26	Insurance-Prop.Liab.Malpractice	0	1,918	0	0	0	0	0	0	0	0	0	1,918	26
27	Other (specify):*	(11,298)	16,309	0	0	0	0	0	0	0	0	0	5,011	27
28	TOTAL General Administration	(76,748)	98,859	0	22,111	28								
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(80,447)	104,256	0	23,809	29								

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER# 0035642

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

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

	Capital Expense	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)	
	D. Ownership													
30	Depreciation	(232)	0	804	17,900	0	0	0	0	0	0	0	18,472	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(724)	0	1,944	91,318	0	0	0	0	0	0	0	92,538	32
33	Real Estate Taxes	0	0	955	0	0	0	0	0	0	0	0	955	33
34	Rent-Facility & Grounds	0	0	0	(138,188)	0	0	0	0	0	0	0	(138,188)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(956)	0	3,703	(28,970)	0	(26,223)	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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(81,403)	104,256	3,703	(28,970)	0	0	0	0	0	0	0	(2,414)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WILLIAM IRVINE	50			HI CARE MANAGEMENT	SPRINGFIELD	MANAGEMENT
		SEE ATTACHED SCHEDULE				
ROBERT HEDGES	50			H.I. PROPERTIES	SPRINGFIELD	REAL ESTATE
				HEALTHCARE	SPRINGFIELD	NURSE
				HORIZONS		CONSULTANT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	MANAGEMENT FEES	\$	HI CARE MANAGEMENT		\$		1
2	V	21 HOME OFFICE EXPENSE	12,000	" " "			(12,000)	2
3	V	5 UTILITIES		" " "		761	761	3
4	V	6 MAINTENANCE		" " "		4,518	4,518	4
5	V	7 SCAVENGER & EXTERMIN.		" " "		118	118	5
6	V	17 ADMINISTRATIVE		" " "		58,284	58,284	6
7	V	19 PROFESSIONAL FEES		" " "		1,998	1,998	7
8	V	20 DUES & SUBSCRIPTION		" " "		752	752	8
9	V	21 OFFICE EXPENSE		" " "		29,636	29,636	9
10	V	24 TRAVEL & SEMINARS		" " "		551	551	10
11	V	25 TRANSPORTATION		" " "		1,411	1,411	11
12	V	26 INSURANCE		" " "		1,918	1,918	12
13	V	27 PAYROLL TAXES & GRP INS		" " "		16,309	16,309	13
14	Total		\$ 12,000			\$ 116,256	\$ * 104,256	14

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30 DEPRECIATION	\$	H & I PROPERTIES (HOME OFFICE)		\$ 804	\$ 804	15
16	V	32 INTEREST		" " " "		1,944	1,944	16
17	V	33 REAL ESTATE TAXES		" " " "		955	955	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		\$			\$ 3,703	\$ * 3,703	39

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

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. 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	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	34 RENT	\$ 138,188	H & I PROPERTIES (FACILITY)		\$	(138,188)
16	V	30 DEPRECIATION		" " "		17,900	17,900
17	V	32 INTEREST		" " "		91,318	91,318
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 138,188			\$ 109,218	\$ * (28,970)

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

Facility Name & ID Number **TRANSITIONS NURSING & REHAB CEN** # **0035642** Report Period Beginning: **01/01/2009** Ending: **12/31/2009**

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT.	50.00				SALARY	\$ 21,457	17-7	1
2											2
3											3
4	WILLIAM IRVINE	VICE PRESIDENT	OFFICE MGMT.	50.00				SALARY	21,457	17-7	4
5					SEE						5
6					ATTACHED						6
7	MARTHA IRVINE	BOOKKEEPING			SCHEDULE			SALARY	1,581	21-7	7
8											8
9											9
10	DEREK HEDGES	SPECIAL PROJECTS MNGR						SALARY	8,864	17-7	10
11											11
12											12
13								TOTAL	\$ 53,359		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER # 0035642 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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 NO

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

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

1	2	3	4	5	6	7	8	9		
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6		
1	5	UTILITIES	PER RESIDENT DAY	130,175	7	\$ 6,954	\$ 14,251	\$ 761	1	
2	6	MAINTENANCE	PER RESIDENT DAY	130,175	7	41,271	39,501	14,251	4,518	2
3	7	SCAVENGER & EXTERMIN.	PER RESIDENT DAY	130,175	7	1,082	14,251	118	3	
4	17	OFFICER SALARY- IRVINE	PER RESIDENT DAY	130,175	7	196,000	196,000	14,251	21,457	4
5	17	OFFICER SALARY- HEDGES	PER RESIDENT DAY	130,175	7	196,000	196,000	14,251	21,457	5
6	17	DIRECTOR OF OPERATIONS	PER RESIDENT DAY	130,175	7	59,432	59,432	14,251	6,506	6
7	17	SPECIAL PROJ MNGR- HEDGE	PER RESIDENT DAY	130,175	7	80,970	80,970	14,251	8,864	7
8	19	PROFESSIONAL FEES	PER RESIDENT DAY	130,175	7	18,255	14,251	1,998	8	
9	20	DUES & SUBSCRIPTION	PER RESIDENT DAY	130,175	7	6,868	14,251	752	9	
10	21	OFFICE EXPENSE	PER RESIDENT DAY	130,175	7	270,705	223,239	14,251	29,636	10
11	24	TRAVEL & SEMINARS	PER RESIDENT DAY	130,175	7	5,032	14,251	551	11	
12	25	TRANSPORTATION	PER RESIDENT DAY	130,175	7	12,888	14,251	1,411	12	
13	26	INSURANCE	PER RESIDENT DAY	130,175	7	17,518	14,251	1,918	13	
14	27	PAYROLL TAXES & GRP INS	PER RESIDENT DAY	130,175	7	148,977	14,251	16,309	14	
15									15	
16									16	
17									17	
18									18	
19									19	
20									20	
21									21	
22									22	
23									23	
24									24	
25	TOTALS					\$ 1,061,952	\$ 795,142	\$ 116,256	25	

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER # 0035642 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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 NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	PER LICENSED BED	461	7	\$ 6,741	\$ 55	\$ 804	1
2	32	INTEREST	PER LICENSED BED	461	7	16,292	55	1,944	2
3	33	REAL ESTATE	PER LICENSED BED	461	7	8,006	55	955	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 31,039	\$	\$ 3,703	25

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER # 0035642 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

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 NO

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

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

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	\$ 17,900	\$	1	\$ 17,900	1
2	32	INTEREST	DIRECT	1	91,318		1	91,318	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 109,218	\$		\$ 109,218	25

Facility Name & ID Number

TRANSITIONS NURSING & REHAB CENT

0035642

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

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)	\$10,935.00	8/03/05	\$ 1,410,500	\$	8/01/10	0.0700	\$ 91,318	1								
2	US BANK (HI PROP)		X	MORTGAGE (OFFICE)		6/29/05		29,564	6/29/12	0.0635	1,944	2								
3												3								
4												4								
5												5								
Working Capital																				
6												6								
7	COLE TAYLOR BANK		X	LINE OF CREDIT	INTEREST	REVOLE		247,620	REVOLV	PRIME+	14,563	7								
8												8								
9	TOTAL Facility Related				\$10,935.00		\$ 1,410,500	\$ 277,184			\$ 107,825	9								
B. Non-Facility Related*																				
10	IRS, IDR, ETC		X	LATE FEES							684	10								
11												11								
12												12								
13												13								
14	TOTAL Non-Facility Related						\$	\$			\$ 684	14								
15	TOTALS (line 9+line14)						\$ 1,410,500	\$ 277,184			\$ 108,509	15								

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A 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.)

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and

1. Real Estate Tax accrual used on 2008 report.		\$	15,804	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	10,642	2
3. Under or (over) accrual (line 2 minus line 1).		\$	(5,163)	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	10,642	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.		\$	5,479	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	2004	15,527	8	
	2005	16,077	9	
	2006	16,196	10	
	2007	15,804	11	
	2008	10,642	12	
				FOR BHF USE ONLY
	13	FROM R. E. TAX STATEMENT FOR 2008	\$	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.

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER

0035642

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (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).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES 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	<u>NURSING HOME</u>	<u>67,000</u>	<u>1998</u>	<u>\$ 83,295</u>	<u>1</u>
2	<u>OFFICE BUILDING</u>		<u>2005</u>	<u>6,902</u>	<u>2</u>
3	TOTALS	67,000		\$ 90,197	3

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER

0035642

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	55	1998		\$ 698,118	\$ 17,900	39	\$ 17,900	\$	\$ 185,732	4
5										5
6	H&I									6
7	Properties									7
8	office bldg	2005		31,285	804	39	804		2,994	8
	Improvement Type**									
9	PARKING LOT IMPROVEMENTS	1992		17,677	561	31.5	561		9,812	9
10	CURTAIN TRACKS	1993		5,650	179	31.5	179		3,036	10
11	REWIRING WORK	1996		6,043	155	39	155		2,112	11
12	ROOF	1997		66,564	1,707	39	1,707		20,982	12
13	OUTDOOR FLOODLIGHTS	1997		2,856	73	39	73		879	13
14	HANDRAILS& WALL GUARDS	1999		2,524	65	39	65		685	14
15	STORAGE BARN	1999		2,100	54	39	54		569	15
16	BACKFLOW PREVENTER	2000		1,696	62	27.5	62		591	16
17	ROOF	2000		2,680	97	27.5	97		926	17
18	NEW WATER HEATER	2001		3,096	113	27.5	113		965	18
19	ALARM SYSTEM	2001		5,013	182	27.5	182		1,555	19
20	OVERBED LIGHT	2001		3,687	134	27.5	134		1,145	20
21	CARPET	2001		1,730		5				21
22	WATER HEATER TANK	2002		1,678	61	27.5	61		460	22
23	ALARM SYSTEM	2002		4,991	182	27.5	182		1,373	23
24	WATER HEATER	2003		2,846	103	27.5	103		674	24
25	WATER HEATER	2004		5,299	193	27.5	193		1,118	25
26	WINDOWS	2005		35,827	1,303	27.5	1,303		5,212	26
27	SMOKE DETECTORS	2005		1,754	64	27.5	64		291	27
28	STEEL FIRE DOOR	2005		1,974	72	27.5	72		327	28
29	FIRE SYSTEM	2005		1,769	64	27.5	64		290	29
30	CARPETING & TILING	2006		13,437	489	27.5	489		1,853	30
31	WATER SOFTENER	2006		3,425	124	27.5	124		471	31
32	GENERATOR	2006		49,050	1,784	27.5	1,784		5,724	32
33	WATER HEATER	2007		5,007	182	27.5	182		463	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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37 DOORS	2009	\$ 3,691	\$ 117	27.5	\$ 117	\$	\$ 117	37
38 FLOORING	2009	5,152	3,091	5	1,030	(2,061)	1,030	38
39 FLOORING	2009	2,809	1,686	5	562	(1,124)	562	39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 989,428	\$ 31,601		\$ 28,416	\$ (3,185)	\$ 251,948	70

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

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER # 0035642

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 74,580	\$ 3,265	\$ 6,751	\$ 3,486	10 YRS	\$ 51,769	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	33,613					33,613	73
74	related party sl (facility)	77,542					77,542	74
75	TOTALS	\$ 185,735	\$ 3,265	\$ 6,751	\$ 3,486		\$ 162,924	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		95 BUICK CENTRY	2000	\$ 6,181	\$	\$	\$	3	\$ 6,181	76
77		93 FORD WHEEL CHAIR VAN	2008	2,500	950	417	(533)	3	834	77
78										78
79										79
80	TOTALS			\$ 8,681	\$ 950	\$ 417	\$ (533)		\$ 7,015	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)	\$ 1,274,041	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,816	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 35,584	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (232)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 421,887	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.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		55		\$ 138,188			3
4	Additions							4
5								5
6								6
7	TOTAL		55		\$ 138,188			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____*

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 12,143 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

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. _____/2010 \$ _____

13. _____/2011 \$ _____

14. _____/2012 \$ _____

* 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.

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.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
<p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>		

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility		3	4
		1	2		
		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.

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

	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 53,426	\$		\$ 53,426	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,332			2,332	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			54,115			54,115	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 prescripts				35,983		35,983	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			\$		\$ 109,873	\$ 35,983		\$ 145,856	14

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

Facility Name & ID Number **TRANSITIONS NURSING & REHAB CENTER**# **0035642**Report Period Beginning: **01/01/2009**Ending: **12/31/2009****XV. BALANCE SHEET - Unrestricted Operating Fund.**As of **12/31/2009**

(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	\$ 16,075	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance (25,000))	347,431		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,574		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)	\$ 395,080	\$	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	250,334		15
16	Equipment, at Historical Cost	126,565		16
17	Accumulated Depreciation (book methods)	(179,977)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 196,922	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 592,002	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 336,302	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	247,620		29
30	Accrued Salaries Payable	41,677		30
31	Accrued Taxes Payable (excluding real estate taxes)	18,214		31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,642		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	OTHER LOAN	322,870		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 977,325	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	1,231,682		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,231,682	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,209,007	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,617,005)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 592,002	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,357,950)	1
2	Restatements (describe):		2
3	ROUNDING	5	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,357,945)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(259,060)	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)	\$ (259,060)	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)	\$ (1,617,005)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER # 0035642 Report Period Beginning: 01/01/2009

Ending: 12/31/2009

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.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,822,188	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,822,188	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	75,558	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 75,558	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***	40	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 40	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)	\$ 1,897,786	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	424,763	31
32	Health Care	923,260	32
33	General Administration	444,685	33
B. Capital Expense			
34	Ownership	188,169	34
C. Ancillary Expense			
35	Special Cost Centers	145,856	35
36	Provider Participation Fee	30,113	36
D. Other Expenses (specify):			
37	OUT-OF-PERIOD EXPENSES		37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,156,846	40
41	Income before Income Taxes (line 30 minus line 40)**	(259,060)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (259,060)	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **TRANSITIONS NURSING & REHAB CENTER**

0035642

Report Period Beginning: **01/01/2009**

Ending:

12/31/2009

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

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	2,129	2,345	\$ 63,362	\$ 27.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,461	4,939	112,147	22.71	3
4	Licensed Practical Nurses	9,816	10,775	216,423	20.09	4
5	CNAs & Orderlies	31,175	33,494	309,671	9.25	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,881	2,256	28,908	12.81	8
9	Activity Director	1,922	2,137	26,983	12.63	9
10	Activity Assistants	2,378	2,736	22,820	8.34	10
11	Social Service Workers	1,848	2,264	26,911	11.89	11
12	Dietician					12
13	Food Service Supervisor	1,858	2,275	23,243	10.22	13
14	Head Cook	4,828	5,466	42,793	7.83	14
15	Cook Helpers/Assistants	5,124	5,652	44,847	7.93	15
16	Dishwashers					16
17	Maintenance Workers	1,931	2,274	27,443	12.07	17
18	Housekeepers	7,082	7,851	63,244	8.06	18
19	Laundry	3,454	3,911	30,888	7.90	19
20	Administrator	1,519	1,877	57,361	30.56	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,982	2,291	27,328	11.93	23
24	Clerical	1,978	2,211	29,159	13.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: MDS	1,339	1,543	31,658	20.52	32
33	Other(specify) <u>WARD CLERK</u>	398	439	4,017	9.15	33
34	TOTAL (lines 1 - 33)	87,103	96,736	\$ 1,189,206 *	\$ 12.29	34

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

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY \$ 6,414	1-3	35
36	Medical Director	MONTHLY 24,375	9-3	36
37	Medical Records Consultant	18 1,170	10-3	37
38	Nurse Consultant	MONTHLY 3,600	10-3	38
39	Pharmacist Consultant	MONTHLY 814	10-3	39
40	Physical Therapy Consultant	MONTHLY 55	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	0	11-3	44
45	Social Service Consultant	44 2,810	12-3	45
46	Other(specify)			46
47				47
48				48
49	TOTAL (lines 35 - 48)	62 \$ 39,238		49

C. CONTRACT NURSES

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

Facility Name & ID Number TRANSITIONS NURSING & REHAB CENTER

0035642

Report Period Beginning: 01/01/2009 Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL HEALTH CARE ASSOC. \$2849
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,473 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 30,113
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 3,438 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.