FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

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

I. IDPH License ID Number: 0035659

Facility Name: TAMMERLANE HEALTHCARE CENTRE, INC.

Address: 3601 16TH AVENUE (Number) STERLING (City) 61801 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 626-0233 **Fax #** (815) 626-6740

HFS ID Number:

Date of Initial License for Current Owners: 07/01/1989

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BILL WEEAKS **Telephone Number:** (217) 528-2244
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROBERT HEDGES
(Title) PRESIDENT

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

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	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					8
9	SNF/PED					9
10	ICF	23,323	748		24,071	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,323	748		24,071	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.21%

D. How many bed-hold days during this year were paid by the Department?
863 (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 [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

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

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	143,396	12,219	4,248	159,863		159,863		159,863			1
2	Food Purchase		146,441		146,441	(6,586)	139,855	(1,383)	138,472			2
3	Housekeeping	76,322	11,389		87,711		87,711		87,711			3
4	Laundry	24,484	3,719		28,203		28,203		28,203			4
5	Heat and Other Utilities			52,392	52,392		52,392	1,833	54,225			5
6	Maintenance	42,591	2,553	25,404	70,548		70,548	8,032	78,580			6
7	Other (specify):*			5,703	5,703		5,703		5,703			7
8	**TOTAL General Services**	286,793	176,321	87,747	550,861	(6,586)	544,275	8,482	552,757			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	615,951	35,676	17,442	669,069		669,069	12,973	682,042			10
10a	Therapy			4,113	4,113		4,113		4,113			10a
11	Activities	53,269	1,727		54,996		54,996		54,996			11
12	Social Services	141,172		3,292	144,464		144,464		144,464			12
13	CNA Training											13
14	Program Transportation			226	226		226		226			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	810,392	37,403	61,073	908,868		908,868	12,973	921,841			16
	C. General Administration											
17	Administrative	85,768		120,000	205,768		205,768	(42,295)	163,473			17
18	Directors Fees											18
19	Professional Services			40,347	40,347		40,347	(3,005)	37,342			19
20	Dues, Fees, Subscriptions & Promotions			18,565	18,565		18,565	49	18,614			20
21	Clerical & General Office Expenses	20,192	8,011	29,000	57,203		57,203	49,394	106,597			21
22	Employee Benefits & Payroll Taxes			198,100	198,100	6,586	204,686	41,171	245,857			22
23	Inservice Training & Education			2,288	2,288		2,288	42	2,330			23
24	Travel and Seminar			1,636	1,636		1,636	4,393	6,029			24
25	Other Admin. Staff Transportation			9,602	9,602		9,602		9,602			25
26	Insurance-Prop.Liab.Malpractice			28,781	28,781		28,781	1,843	30,624			26
27	Other (specify):*			5,212	5,212		5,212	(5,212)				27
28	**TOTAL General Administration**	105,960	8,011	453,531	567,502	6,586	574,088	46,380	620,468			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,203,145	221,735	602,351	2,027,231		2,027,231	67,835	2,095,066			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 TAMMERLANE HEALTHCARE CENTRE, INC. #0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			8,517	8,517		8,517	27,244	35,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,941	3,941		3,941	95,233	99,174			32
33	Real Estate Taxes			10,525	10,525		10,525	1,039	11,564			33
34	Rent-Facility & Grounds			175,303	175,303		175,303	(175,303)				34
35	Rent-Equipment & Vehicles			12,225	12,225		12,225		12,225			35
36	Other (specify):*											36
37	**TOTAL Ownership**			210,511	210,511		210,511	(51,787)	158,724			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,325	38,325		38,325		38,325			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			38,325	38,325		38,325		38,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,203,145	221,735	851,187	2,276,067		2,276,067	16,048	2,292,115			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 TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,465	30		9
10	Interest and Other Investment Income	(154)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,383)	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	(336)	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	(4,500)	27		24
25	Fund Raising, Advertising and Promotional	(190)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(376)	27		28
29	Other-Attach Schedule	(18,000)	19		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (21,474)		$	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)	37,522		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 37,522		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 16,048		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

TAMMERLANE HEALTHCARE CENTRE, INC.

ID# 0035659

Report Period Beginning: 01/01/2011

Ending: 12/31/2011

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	HEALTHCARE HORIZONS	$ (18,000)	19	1
2				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				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**	(18,000)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,383)	0	0	0	0	0	0	0	0	0	0	(1,383)	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	1,833	0	0	0	0	0	0	0	0	0	1,833	5
6	Maintenance	0	8,032	0	0	0	0	0	0	0	0	0	8,032	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,383)	9,865	0	0	0	0	0	0	0	0	0	8,482	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	12,973	0	0	0	0	0	0	0	0	0	12,973	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	12,973	0	0	0	0	0	0	0	0	0	12,973	16
	C. General Administration													
17	Administrative	0	(42,295)	0	0	0	0	0	0	0	0	0	(42,295)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,000)	14,610	385	0	0	0	0	0	0	0	0	(3,005)	19
20	Fees, Subscriptions & Promotions	(190)	239	0	0	0	0	0	0	0	0	0	49	20
21	Clerical & General Office Expenses	0	49,286	108	0	0	0	0	0	0	0	0	49,394	21
22	Employee Benefits & Payroll Taxes	0	41,171	0	0	0	0	0	0	0	0	0	41,171	22
23	Inservice Training & Education	0	42	0	0	0	0	0	0	0	0	0	42	23
24	Travel and Seminar	0	4,393	0	0	0	0	0	0	0	0	0	4,393	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,843	0	0	0	0	0	0	0	0	0	1,843	26
27	Other (specify):*	(5,212)	0	0	0	0	0	0	0	0	0	0	(5,212)	27
28	**TOTAL General Administration**	(23,402)	69,289	493	0	0	0	0	0	0	0	0	46,380	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,785)	92,127	493	0	0	0	0	0	0	0	0	67,835	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

	Capital Expense	PAGES 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	3,465	0	1,010	22,769	0	0	0	0	0	0	0	27,244	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(154)	0	1,878	93,509	0	0	0	0	0	0	0	95,233	32
33	Real Estate Taxes	0	0	1,039	0	0	0	0	0	0	0	0	1,039	33
34	Rent-Facility & Grounds	0	0	0	(175,303)	0	0	0	0	0	0	0	(175,303)	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**	3,311	0	3,927	(59,025)	0	0	0	0	0	0	0	(51,787)	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)**	(21,474)	92,127	4,420	(59,025)	0	0	0	0	0	0	0	16,048	45

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 120,000	HI CARE MANAGEMENT		$	$ (120,000)	1
2	V	21	HOME OFFICE EXPENSE	13,000	HI CARE MANAGEMENT			(13,000)	2
3	V	6	MAINTENANCE		HI CARE MANAGEMENT		8,032	8,032	3
4	V	5	UTILITIES		HI CARE MANAGEMENT		1,833	1,833	4
5	V	10	NURSING		HI CARE MANAGEMENT		12,973	12,973	5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT		77,705	77,705	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		62,286	62,286	7
8	V	19	PROFESSIONAL SERVICES		HI CARE MANAGEMENT		14,610	14,610	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		239	239	9
10	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		42	42	10
11	V	24	TRAVEL		HI CARE MANAGEMENT		4,393	4,393	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		1,843	1,843	12
13	V	22	PAYROLL TAX AND BENEFITS				41,171	41,171	13
14	Total			$ 133,000			$ 225,127	$ * 92,127	14

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES (HOME OFFICE)		$ 1,010	$ 1,010	15
16	V	32	INTEREST		H&I PROPERTIES (HOME OFFICE)		1,878	1,878	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES (HOME OFFICE)		1,039	1,039	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES (HOME OFFICE)		385	385	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES (HOME OFFICE)		108	108	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			$			$ 4,420	$ * 4,420	39

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 175,303	H&I PROPERTIES (FACILITY)		$	$ (175,303)	15
16	V	30	DEPRECIATION		H&I PROPERTIES (FACILITY)		22,769	22,769	16
17	V	32	INTEREST		H&I PROPERTIES (FACILITY)		93,509	93,509	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			$ 175,303			$ 116,278	$ * (59,025)	39

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ 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			$			$	$	15
16	V								16
17	V								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			$			$ 0	$ *	39

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								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								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50.00				SALARY	$ 32,348	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50.00	SEE ATTACHED			SALARY	31,026	17-7	2
3	MARTHA IRVINE	BOOKKEEPING			SCHEDULE			SALARY	2,417	21-7	3
4	DEREK HEDGES	OPERATIONS						SALARY	14,331	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 80,122		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 TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: HI CARE MANAGEMENT, INC.
Street Address: 827 S 5TH STREET
City / State / Zip Code: SPRINGFIELD, IL 62703
Phone Number: ((217) 528-0044
Fax Number: ((217) 528-3412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE	PER RESIDENT DAY	143,838	8	$ 47,997	$ 38,912	24,071	$ 8,032	1
2	5	UTILITIES	PER RESIDENT DAY	143,838	8	10,952		24,071	1,833	2
3	10	NURSING	PER RESIDENT DAY	143,838	8	77,520	77,520	24,071	12,973	3
4	17	ADMINISTRATION	PER RESIDENT DAY	143,838	8	464,334	464,334	24,071	77,705	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	143,838	8	372,195	290,523	24,071	62,286	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	143,838	8	87,301		24,071	14,610	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	143,838	8	1,428		24,071	239	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	143,838	8	250		24,071	42	8
9	24	TRAVEL	PER RESIDENT DAY	143,838	8	26,248		24,071	4,393	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	143,838	8	11,015		24,071	1,843	10
11	22	PAYROLL TAX AND BENEFITS	PER RESIDENT DAY	143,838	8	246,018		24,071	41,171	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,345,258	$ 871,289		$ 225,127	25

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: H&I PROPERTIES-HOME OFFICE
Street Address: 1625 S 6TH 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	PER LICENSE BED	564	8	$ 8,134	$	70	$ 1,010	1
2	32	INTEREST	PER LICENSE BED	564	8	15,128		70	1,878	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	564	8	8,372		70	1,039	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	564	8	3,100		70	385	4
5	21	OFFICE EXPENSE	PER LICENSE BED	564	8	869		70	108	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,603	$		$ 4,420	25

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 2/31/2011

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: H&I PROPERTIES-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	$ 22,769	$	1	$ 22,769	1
2	32	INTEREST	DIRECT	1	1	93,509		1	93,509	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					$ 116,278	$		$ 116,278	25

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	COLE TAYLOR (H&I PROP)		X	MORTGAGE (FACILITY)	$12,851.10	8/3/2005	$ 1,689,500	$ 1,386,351	08/15/2015	0.0650	$ 93,509	1
2	US BAMK (H&I PROP)		X	MORTGAGE (OFFICE)		6/29/2005		28,509	06/29/2012	0.0635	1,878	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR		X	WORKING CAPITAL	INTEREST	REVOLV		200,000		PRIME+	3,941	6
7												7
8												8
9	TOTAL Facility Related				$12,851.10		$ 1,689,500	$ 1,614,860			$ 99,328	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,689,500	$ 1,614,860			$ 99,328	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.)**

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 10,093	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.)		$ 11,348	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,255	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 10,309	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.		$ 11,564	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	16,066	8
	2007	16,312	9
	2008	9,872	10
	2009	10,093	11
	2010	11,348	12

2011 accrual based on 2010 tax.

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

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TAMMERLANE HEALTHCARE CENTRE, INC. COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035659

CONTACT PERSON REGARDING THIS REPORT BILL WEEAKS

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

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

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

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-10-329-006	NURSING HOME	$ 10,309.20	$ 10,309.20
2.	22-03.0-107-017	HOME OFFICE	$ 3,342.98	$ 415.00
3.	22-03.0-107-018	HOME OFFICE	$ 5,029.40	$ 624.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,681.58	$ 11,348.20

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,130 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 2

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	217,800	1998	$ 111,500	1
2	HOME OFFICE		2005	7,199	2
3	TOTALS	217,800		$ 118,699	3

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70		1998	1958	$ 887,968	$ 22,769	39	$ 22,769	$	$ 304,535	4
5											5
6	H&I										6
7	PROPERTIES										7
8	OFFC BLD			2005	32,629	1,010	39	1,010		5,403	8
	Improvement Type**										
9	IMPROVEMENTS			1992	14,227	452	31.5	452		8,704	9
10	IMPROVEMENTS			1993	3,670	94	39	94		1,712	10
11	IMPROVEMENTS			1994	7,850	201	39	201		3,439	11
12	PLUMBING WORK			1995	3,302	85	39	85		1,413	12
13	INSTALLED BOILER TANK			1995	600	15	39	15		250	13
14	INSTALLED 2 PUMPS			1995	2,289	59	39	59		976	14
15	PLUMBING WORK			1995	10,752	276	39	276		4,543	15
16	DOORS			1995	2,094	54	39	54		875	16
17	TWO DOORS			1995	1,055	27	39	27		435	17
18	INSTALLED ATTIC FAN & DUCT			1995	2,412	62	39	62		995	18
19	PARKING LOT			1995	32,070		15			32,070	19
20	WALL PROTECTOR			1997	3,328	85	39	85		1,258	20
21	SEPTIC FIELD PLUMBING WORK			1998	25,965	666	39	666		8,741	21
22	2 NEW WATER HEATERS			1999	12,083	310	39	310		3,887	22
23	CIRCUIT BREAKER PANELS			1999	2,230	57	39	57		715	23
24	ELECTRICAL WORK			1999	2,374	61	39	61		765	24
25	BREAKER PANELS			2001	2,542	92	27.5	92		970	25
26	BLACKTOP			2001	11,161	744	15	744		7,843	26
27	BOILER			2003	9,911	360	37.5	360		2,895	27
28	WINDOWS			2005	1,832	67	27.5	67		410	28
29	MAIN BREAKER PANEL			2005	13,684	498	27.5	498		3,051	29
30	ALARM SYSTEM			2005	20,688	752	27.5	752		4,543	30
31	CONCRETE WALKWAY			2005	1,800	120	15	120		745	31
32	FIRE SYSTEM			2005	1,769	64	27.5	64		384	32
33	OUTDOOR WIRELESS MONITORING SYSTEM			2006	7,405	269	27.5	269		1,491	33
34	ELECTRICAL WORK			2006	2,379	87	27.5	87		482	34
35	WANDER GUARD SYSTEM			2006	5,893	214	27.5	214		1,186	35
36	DOORS			2006	2,321	85	27.5	85		471	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 TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	2006	$ 7,399	$ 269	27.5	$ 269	$	$ 1,491	37
38	PLUMBING	2007	9,763	651	15	651		3,065	38
39									39
40									40
41									41
42									42
43									43
44	DOORS	2008	6,830	248	27.5	248		878	44
45	BACKFLOW PLUMBING FIRE SPRINKLER	2009	5,889	214	27.5	214		526	45
46	FIRE ESCAPE STAIRCASE	2009	13,192	480	27.5	480		1,180	46
47	CONCRETE FOR SIDEWALK	2010	4,225	282	15	282		317	47
48									48
49	SIDEWALK REPLACEMENT	2011	3,229	27	15	27		27	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,178,810	$ 31,806		$ 31,806	$	$ 412,671	70

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 42,391	$ 490	$ 3,955	$ 3,465		$ 31,262	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	55,643					55,643	73
74								74
75	TOTALS	$ 98,034	$ 490	$ 3,955	$ 3,465		$ 86,905	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	HSKP,NRSG,ACTIVITIES	2000 CHEVY TRUCK	2002	$ 28,556	$	$	$		$ 28,556	76
77	HSKP,NRSG,ACTIVITIES	2001 DODGE VAN	2004	10,725					10,725	77
78										78
79										79
80	TOTALS			$ 39,281	$	$	$		$ 39,281	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)	$ 1,434,824	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,296	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 35,761	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,465	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 538,857	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 TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: H&I PROPERTIES

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		70		$ 175,303			3
4	Additions							4
5								5
6								6
7	TOTAL		70		$ 175,303 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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: *

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: $ 12,225 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 TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

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

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

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							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			$		$	$		$	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 TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XV. BALANCE SHEET - Unrestricted Operating Fund.

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

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 59,448	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,000)	405,932		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,045		6
7	Other Prepaid Expenses	167		7
8	Accounts Receivable (owners or related parties)	172,035		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 638,627	$	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	258,213		15
16	Equipment, at Historical Cost	137,315		16
17	Accumulated Depreciation (book methods)	(238,867)		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)**	$ 156,661	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 795,288	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,608	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	200,000		29
30	Accrued Salaries Payable	55,696		30
31	Accrued Taxes Payable (excluding real estate taxes)	1,897		31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,309		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 355,510	$	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				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 355,510	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 439,778	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 795,288	$	48

***(See instructions.)**

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 429,067	1
2	Restatements (describe):		2
3	POST CLOSING	(493)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 428,574	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	11,204	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)**	$ 11,204	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)**	$ 439,778	24 *

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,293,701	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,293,701	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	154	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 154	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)**	$ 2,293,855	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	544,275	31
32	Health Care	908,868	32
33	General Administration	574,088	33
	B. Capital Expense		
34	Ownership	210,511	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	38,325	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,276,067	40
41	**Income before Income Taxes (line 30 minus line 40)****	17,788	41
42	**Income Taxes**	(6,584)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 11,204	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.**

CASH BASIS TAX

*** **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 TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,080	$ 60,115	$ 28.90	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,861	3,223	94,870	29.44	3
4	Licensed Practical Nurses	7,965	8,586	162,387	18.91	4
5	CNAs & Orderlies	22,458	24,246	242,102	9.99	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,769	2,034	20,975	10.31	9
10	Activity Assistants	3,392	3,792	32,294	8.52	10
11	Social Service Workers	11,428	12,122	141,172	11.65	11
12	Dietician					12
13	Food Service Supervisor	1,808	1,808	25,267	13.98	13
14	Head Cook	5,019	5,498	47,867	8.71	14
15	Cook Helpers/Assistants	7,706	8,131	70,262	8.64	15
16	Dishwashers					16
17	Maintenance Workers	3,656	4,341	42,591	9.81	17
18	Housekeepers	7,631	8,596	76,322	8.88	18
19	Laundry	2,705	2,887	24,484	8.48	19
20	Administrator	1,752	2,080	85,768	41.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	958	1,297	20,192	15.57	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		81	691	8.53	31
32	Other Health C: MDS,TRANSP	3,413	3,884	55,786	14.36	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	86,425	94,686	$ 1,203,145 *	$ 12.71	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	MONTHLY	$ 4,248	1-3	35
36	Medical Director	MONTHLY	36,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	MONTHLY	1,842	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	82	4,113	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	27	1,080	12-3	45
46	Other(specify) PSYCHIATRIC	MONTHLY	15,600	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	109	$ 62,883		49

C. CONTRACT NURSES

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY REESE	ADMINISTRATOR	0	$ 85,768
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 85,768

B. Administrative - Other

Description	Amount
HI CARE MANAGEMENT	$ 120,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 120,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED		$ 37,342
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 37,342

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,357
Unemployment Compensation Insurance	11,579
FICA Taxes	100,431
Employee Health Insurance	65,633
Employee Meals	6,586
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS OTHER	5,951
PENSION PLANS	3,320
TOTAL (agree to Schedule V, line 22, col.8)	$ 245,857

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

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	155
Health Care Worker Background Check (Indicate # of checks performed 11)	355
Patient Background Checks 6	101
SEE ATTACHED	14,023
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,614

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
CORP DON	4,119
Seminar Expense	
IHCA CONVENTION	1,867
INHAA	16
ILLINOIS PIONEER COALITION	27
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,029

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 Report Period Beginning: 01/01/2011 Ending: 12/31/2011

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

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

Facility Name & ID Number TAMMERLANE HEALTHCARE CENTRE, INC. # 0035659 **Report Period Beginning:** 01/01/2011 **Ending:** 12/31/2011

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $3864, ICLTC $6675**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **38,325**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **6,586** 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?
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?
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.

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

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

TOTAL FOOD PURCHASE	$	138,275
LESS SALES TAX	$	(1,383)
NET FOOD	$	136,892
TOTAL PATIENT CENSUS		24,071
MEALS PER DAY		3
TOTAL PATIENT MEALS		72,213
EMPLOYEES MEALS PER DAY		10
DAYS PER YEAR		365
TOTAL EMPLOYEE MEALS		3,650
TOTAL MEALS PER YEAR		75,863
COST PER MEAL	$	1.80
TOTAL EMPLOYEE MEAL COST	$	6,586

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX - DUES FEES SUBSCRIPTIONS AND PROMOTIONS

IHCA	$	3,864
ILLINOIS COUNCIL ON LTC	$	6,675
E HEALTH SOLUTIONS	$	2,430
SAULK VALLEY NEWSPAPER	$	197
ILLINOIS SECRETARY OF STATE	$	298
WHITESIDE COUNTY	$	170
CLIA LAB PGM	$	150
ALEXANDER HAMILTON EMPLOYEE LAW	$	7
WOLTERS OSHA GUIDE	$	24
MEDPASS MAUNALS	$	69
AICPA ACCTG GUIDES	$	123
TAX SOFTWARE	$	16
	$	14,023

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE XIX - PROFESSIONAL SERVICES

MDI SOFTWARE SUPPORT	$	10,407
ITT SOFTWARE SUPPORT	$	655
ACCUMED MDS SOFTWARE SUPPORT	$	3,780
KBKB ACCTG SVCS	$	13,719
CTB LEGAL	$	805
GOLDASICH CONSULT	$	808
CGH MEDICAL POC	$	1,200
BPC 401K ADMIN	$	1,151
CT CORP AGENT	$	113
ILLINOIS DEP OF REGULATION	$	20
MARGEL PEDDICORD CONSULT	$	285
STRATTON LEGAL	$	2,446
SANDBERG LEGAL	$	169
IVANS SOFTWARE SUPPORT	$	789
EMDEON IT	$	166
ILLINI TECH IT	$	135
PEHLMAN ACCTG SVCS	$	694
	$	37,342

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE V, LINE 23 INSERVICE TRAINING AND EDUCATION

ADULT CPR	$	348
RELATIONAL/CONCEPTUAL RECERT	$	765
IHCA NURSING ACADEMY WEB ACCESS	$	950
MANUALS	$	225
LTCNA	$	42
	$	2,330

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
Cameras	$ 2,700
Dishwasher	$ 963
Floor Mats	$ 2,995
Milk Cooler	$ 995
Copier	$ 4,572
TOTALS	$ 12,225

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/11

OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	AMOUNT
TRANSPORT VAN FUEL AND REPAIRS	$ 9,602
TOTALS	$ 9,602