FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 0035659

Facility Name: TAMMERLANE HEALTH CARE CENTRE

Address: 3601 SIXTEENTH AVENUE (Number) STERLING (City) 61081 (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 1/1/2012 to 12/31/2012 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROBERT HEDGES
(Title) PRESIDENT

Paid Preparer

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

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,620	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,620	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	23,153	1,002		24,155	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,153	1,002		24,155	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.28%

D. How many bed-hold days during this year were paid by the Department?
321 (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: 12/31/2012 Fiscal Year: 12/31/2012

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	141,900	10,772	3,541	156,213		156,213		156,213			1
2	Food Purchase		133,661		133,661	(6,277)	127,384	(1,319)	126,065			2
3	Housekeeping	80,649	11,342		91,991		91,991		91,991			3
4	Laundry	24,345	3,672		28,017		28,017		28,017			4
5	Heat and Other Utilities			44,532	44,532		44,532	(912)	43,620			5
6	Maintenance	36,966	2,918	22,201	62,085		62,085	9,987	72,072			6
7	Other (specify):*			5,355	5,355		5,355		5,355			7
8	TOTAL General Services	283,860	162,365	75,629	521,854	(6,277)	515,577	7,756	523,333			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	628,635	28,381	16,328	673,344		673,344	16,936	690,280			10
10a	Therapy			3,850	3,850		3,850		3,850			10a
11	Activities	40,402	1,632		42,034		42,034		42,034			11
12	Social Services	142,322		3,951	146,273		146,273		146,273			12
13	CNA Training											13
14	Program Transportation			182	182		182		182			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	811,359	30,013	60,311	901,683		901,683	16,936	918,619			16
	C. General Administration											
17	Administrative	85,798		116,499	202,297		202,297	(13,566)	188,731			17
18	Directors Fees											18
19	Professional Services			14,776	14,776		14,776	13,069	27,845			19
20	Dues, Fees, Subscriptions & Promotions			6,979	6,979		6,979	275	7,254			20
21	Clerical & General Office Expenses	19,816	6,386	24,976	51,178		51,178	64,298	115,476			21
22	Employee Benefits & Payroll Taxes			192,669	192,669	6,277	198,946	44,074	243,020			22
23	Inservice Training & Education			307	307		307	639	946			23
24	Travel and Seminar							3,458	3,458			24
25	Other Admin. Staff Transportation			7,882	7,882		7,882		7,882			25
26	Insurance-Prop.Liab.Malpractice			29,512	29,512		29,512	3,034	32,546			26
27	Other (specify):*			16,787	16,787		16,787	(16,787)				27
28	TOTAL General Administration	105,614	6,386	410,387	522,387	6,277	528,664	98,494	627,158			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,200,833	198,764	546,327	1,945,924		1,945,924	123,186	2,069,110			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 HEALTH CARE CENTRE #0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			8,700	8,700		8,700	27,586	36,286			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			9,264	9,264		9,264	84,031	93,295			32
33	Real Estate Taxes			9,935	9,935		9,935	1,354	11,289			33
34	Rent-Facility & Grounds			169,303	169,303		169,303	(169,303)				34
35	Rent-Equipment & Vehicles			13,288	13,288		13,288		13,288			35
36	Other (specify):*											36
37	**TOTAL Ownership**			210,490	210,490		210,490	(56,332)	154,158			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			293,676	293,676		293,676		293,676			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			293,676	293,676		293,676		293,676			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,200,833	198,764	1,050,493	2,450,090		2,450,090	66,854	2,516,944			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 HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,712)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,674	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,319)	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	(16,067)	27		24
25	Fund Raising, Advertising and Promotional	(2,874)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(384)	27		28
29	Other-Attach Schedule	(13,575)	19		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (33,593)		$	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)	100,447		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 100,447		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 66,854		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 HEALTH CARE CENTRE

ID# 0035659

Report Period Beginning: 1/1/2012

Ending: 12/31/2012

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	HEALTHCARE HORIZONS	$ (9,000)	19	1
2	PRIOR YR COSTS BKD	(2,035)	19	2
3	PRIOR YR COSTS CT	(173)	19	3
4	NON INCLUDABLE	(89)	19	4
5	NON INCLUDABLE LEGAL	(75)	19	5
6	NON INCLUDABLE LEGAL	(2,203)	19	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**	(13,575)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,319)	0	0	0	0	0	0	0	0	0	0	(1,319)	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	(2,712)	1,800	0	0	0	0	0	0	0	0	0	(912)	5
6	Maintenance	0	9,987	0	0	0	0	0	0	0	0	0	9,987	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,031)	11,787	0	0	0	0	0	0	0	0	0	7,756	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	16,936	0	0	0	0	0	0	0	0	0	16,936	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	16,936	0	0	0	0	0	0	0	0	0	16,936	16
	C. General Administration													
17	Administrative	0	(13,566)	0	0	0	0	0	0	0	0	0	(13,566)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,575)	20,725	472	5,447	0	0	0	0	0	0	0	13,069	19
20	Fees, Subscriptions & Promotions	(2,874)	3,149	0	0	0	0	0	0	0	0	0	275	20
21	Clerical & General Office Expenses	0	64,107	191	0	0	0	0	0	0	0	0	64,298	21
22	Employee Benefits & Payroll Taxes	0	44,074	0	0	0	0	0	0	0	0	0	44,074	22
23	Inservice Training & Education	0	639	0	0	0	0	0	0	0	0	0	639	23
24	Travel and Seminar	0	3,458	0	0	0	0	0	0	0	0	0	3,458	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	3,034	0	0	0	0	0	0	0	0	0	3,034	26
27	Other (specify):*	(16,787)	0	0	0	0	0	0	0	0	0	0	(16,787)	27
28	**TOTAL General Administration**	(33,236)	125,620	663	5,447	0	0	0	0	0	0	0	98,494	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,267)	154,343	663	5,447	0	0	0	0	0	0	0	123,186	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 **Report Period Beginning:** 1/1/2012 **Ending:** 12/31/2012

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,674	0	1,137	22,775	0	0	0	0	0	0	0	27,586	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	1,792	82,239	0	0	0	0	0	0	0	84,031	32
33	Real Estate Taxes	0	0	1,354	0	0	0	0	0	0	0	0	1,354	33
34	Rent-Facility & Grounds	0	0	0	(169,303)	0	0	0	0	0	0	0	(169,303)	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	3,674	0	4,283	(64,289)	0	0	0	0	0	0	0	(56,332)	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)	(33,593)	154,343	4,946	(58,842)	0	0	0	0	0	0	0	66,854	45

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES

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

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

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 116,499	HI CARE MANAGEMENT		$	$ (116,499)	1
2	V	21	HOME OFFICE EXPENSE	6,000	HI CARE MANAGEMENT			(6,000)	2
3	V	6	MAINTENANCE		HI CARE MANAGEMENT		9,987	9,987	3
4	V	5	UTILITIES		HI CARE MANAGEMENT		1,800	1,800	4
5	V	10	NURSING		HI CARE MANAGEMENT		16,936	16,936	5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT		102,933	102,933	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		70,107	70,107	7
8	V	19	PROFESSIONAL SERVICES		HI CARE MANAGEMENT		20,725	20,725	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		3,149	3,149	9
10	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		639	639	10
11	V	24	TRAVEL		HI CARE MANAGEMENT		3,458	3,458	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		3,034	3,034	12
13	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT		44,074	44,074	13
14	Total			$ 122,499			$ 276,842	$ * 154,343	14

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	DEPRECIATION		$ 1,137	$ 1,137	15
16	V	32	INTEREST		INTEREST		1,792	1,792	16
17	V	33	REAL ESTATE TAXES		REAL ESTATE TAXES		1,354	1,354	17
18	V	19	PROFESSIONAL FEES		PROFESSIONAL FEES		472	472	18
19	V	21	OFFICE EXPENSE		OFFICE EXPENSE		191	191	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			$			$ 4,946	$ * 4,946	39

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 169,303	H&I PROPERTIES (FACILITY)		$	$ (169,303)	15
16	V	30	DEPRECIATION		H&I PROPERTIES (FACILITY)		22,775	22,775	16
17	V	32	INTEREST		H&I PROPERTIES (FACILITY)		82,239	82,239	17
18	V	19	PROFESSIONAL SERVICES		H&I PROPERTIES (FACILITY)		5,447	5,447	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			$ 169,303			$ 110,461	$ * (58,842)	39

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTR # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50.00	SEE ATTACHED			SALARY	$ 41,401	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50.00	SCHEDULE			SALARY	39,710	17-7	2
3	MARTHA IRVINE	BOOKKEEPING						SALARY	3,093	21-7	3
4	DEREK HEDGES	OPERATIONS						SALARY	18,729	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 102,933		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 HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: HI CARE MANAGEMENT, INC.
Street Address: 1625 S 6TH 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	112,777	5	$ 46,629	$ 39,723	24,155	$ 9,987	1
2	5	UTILITIES	PER RESIDENT DAY	112,777	5	8,403		24,155	1,800	2
3	10	NURSING	PER RESIDENT DAY	112,777	5	79,070	79,070	24,155	16,936	3
4	17	ADMINISTRATION	PER RESIDENT DAY	112,777	5	480,583	480,583	24,155	102,933	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	112,777	5	327,320	265,760	24,155	70,107	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	112,777	5	96,762		24,155	20,725	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	112,777	5	14,702		24,155	3,149	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	112,777	5	2,984		24,155	639	8
9	24	TRAVEL	PER RESIDENT DAY	112,777	5	16,146		24,155	3,458	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	112,777	5	14,166		24,155	3,034	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	112,777	5	205,777		24,155	44,074	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,292,542	$ 865,136		$ 276,842	25

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: H&I PROPERTIES-HOME OFFICE
Street Address: 1625 S 6TH 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	444	5	$ 7,213	$	70	$ 1,137	1
2	32	INTEREST	PER LICENSE BED	444	5	11,364		70	1,792	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	444	5	8,587		70	1,354	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	444	5	2,993		70	472	4
5	21	OFFICE EXPENSE	PER LICENSE BED	444	5	1,214		70	191	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 31,371	$		$ 4,946	25

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: H&I PROPERTIES-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	$ 22,775	$	1	$ 22,775	1
2	32	INTEREST	DIRECT	1	1	82,239		1	82,239	2
3	19	PROFESSIONAL SERVICES	DIRECT	1	1	5,447		1	5,447	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					$ 110,461	$		$ 110,461	25

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	COLE TAYLOR (H&I PROP)		X	MORTGAGE (FACILITY)	$13,205.00	8/3/2005	$ 1,689,500	$ 1,327,228	08/15/2015	0.0650	$ 82,239	1
2	US BANK (H&I PROP)		X	MORTGAGE (OFFICE)		6/29/2005		34,613	06/29/2017	0.0425	1,792	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR		X	WORKING CAPITAL	INTEREST	REVOLV		125,000		PRIME+	9,264	6
7												7
8												8
9	TOTAL Facility Related				$13,205.00		$ 1,689,500	$ 1,486,841			$ 93,295	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	$ 1,486,841			$ 93,295	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2011 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 11,564	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.)		$ 11,476	2
3. Under or (over) accrual (line 2 minus line 1).		$ (88)	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 11,377	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.		$ 11,289	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2007	16,312	8
	2008	9,872	9
	2009	10,093	10
	2010	11,348	11
	2011	11,476	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TAMMERLANE HEALTH CARE CENTRE 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 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-10-329-006	NURSING HOME	$ 10,122.26	$ 10,122.26
2.	22-03.0-107-017	HOME OFFICE	$ 3,428.58	$ 540.54
3.	22-03.0-107-018	HOME OFFICE	$ 5,158.22	$ 813.23
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,709.06	$ 11,476.03

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

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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	9,144	2
3	TOTALS	217,800		$ 120,644	3

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70		1998	1958	$ 887,968	$ 22,769	39	$ 22,769	$	$ 327,304	4
5											5
6	H&I										6
7	PROPERTIES										7
8	OFFC BLD			2005	41,448	1,143	39	1,143		6,546	8
	Improvement Type**										
9	IMPROVEMENTS			1992	14,227	452	31.5	452		9,156	9
10	IMPROVEMENTS			1993	3,670	94	39	94		1,806	10
11	IMPROVEMENTS			1994	7,850	201	39	201		3,640	11
12	PLUMBING WORK			1995	3,302	85	39	85		1,498	12
13	INSTALLED BOILER TANK			1995	600	15	39	15		265	13
14	INSTALLED 2 PUMPS			1995	2,289	59	39	59		1,035	14
15	PLUMBING WORK			1995	10,752	276	39	276		4,819	15
16	DOORS			1995	2,094	54	39	54		929	16
17	TWO DOORS			1995	1,055	27	39	27		462	17
18	INSTALLED ATTIC FAN & DUCT			1995	2,412	62	39	62		1,057	18
19	PARKING LOT			1995	32,070		15			32,070	19
20	WALL PROTECTOR			1997	3,328	85	39	85		1,343	20
21	SEPTIC FIELD PLUMBING WORK			1998	25,965	666	39	666		9,407	21
22	2 NEW WATER HEATERS			1999	12,083	310	39	310		4,197	22
23	CIRCUIT BREAKER PANELS			1999	2,230	57	39	57		772	23
24	ELECTRICAL WORK			1999	2,374	61	39	61		826	24
25	BREAKER PANELS			2001	2,542	92	27.5	92		1,062	25
26	BLACKTOP			2001	11,161	744	15	744		8,587	26
27	BOILER			2003	9,911	360	37.5	360		3,255	27
28	WINDOWS			2005	1,832	67	27.5	67		477	28
29	MAIN BREAKER PANEL			2005	13,684	498	27.5	498		3,549	29
30	ALARM SYSTEM			2005	20,688	752	27.5	752		5,295	30
31	CONCRETE WALKWAY			2005	1,800	120	15	120		865	31
32	FIRE SYSTEM			2005	1,769	63	27.5	63		447	32
33	OUTDOOR WIRELESS MONITORING SYSTEM			2006	7,405	269	27.5	269		1,760	33
34	ELECTRICAL WORK			2006	2,379	87	27.5	87		569	34
35	WANDER GUARD SYSTEM			2006	5,893	214	27.5	214		1,400	35
36	DOORS			2006	2,321	85	27.5	85		556	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 HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	2006	$ 7,399	$ 268	27.5	$ 268	$	$ 1,759	37
38	PLUMBING	2007	9,763	651	15	651		3,716	38
39									39
40									40
41	DOORS	2008	6,830	248	27.5	248		1,126	41
42	BACKFLOW PLUMBING FIRE SPRINKLER	2009	5,889	214	27.5	214		740	42
43	FIRE ESCAPE STAIRCASE	2009	13,192	480	27.5	480		1,660	43
44	CONCRETE FOR SIDEWALK	2010	4,225	282	15	282		599	44
45									45
46	SIDEWALK REPLACEMENT	2011	3,229	215	15	215		242	46
47									47
48	DOORS	2012	3,134	70	39	70		70	48
49	WATER HEATER	2012	6,677	136	39	136		136	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)		$ 1,197,440	$ 32,331		$ 32,331	$	$ 445,002	70

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 42,391	$ 281	$ 3,955	$ 3,674		$ 35,217	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	55,643					55,643	73
74								74
75	TOTALS	$ 98,034	$ 281	$ 3,955	$ 3,674		$ 90,860	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)	$ 1,455,399	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,612	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 36,286	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,674	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 575,143	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 HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		70		$ 169,303			3
4	Additions							4
5								5
6								6
7	TOTAL		70		$ 169,303 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2013	$
13.	/2014	$
14.	/2015	$

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

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

16. Rental Amount for movable equipment: $ 13,288 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 HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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 HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2012 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,999	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,000)	504,216		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,485		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	123,752		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 645,452	$	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	268,024		15
16	Equipment, at Historical Cost	137,315		16
17	Accumulated Depreciation (book methods)	(247,567)		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)**	$ 157,772	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 803,224	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 172,877	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	125,000		29
30	Accrued Salaries Payable	54,471		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	10,122		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)**	$ 362,470	$	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)**	$ 362,470	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 440,754	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 803,224	$	48

***(See instructions.)**

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 439,778	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 439,778	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	976	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)**	$ 976	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)**	$ 440,754	24	*

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,451,016	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,451,016	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***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	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)**	$ 2,451,016	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	521,854	31
32	Health Care	901,683	32
33	General Administration	522,387	33
	B. Capital Expense		
34	Ownership	210,490	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	293,676	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,450,090	40
41	**Income before Income Taxes (line 30 minus line 40)****	926	41
42	**Income Taxes**	50	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 976	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,374,525	44
45	Private Pay - Net Inpatient Revenue	76,491	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 2,451,016	49

* **This must agree with page 4, line 45, column 4.** **TAX IS CASH BASIS**

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

*** **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 HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,904	2,072	$ 60,593	$ 29.24	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,708	2,989	87,978	29.43	3
4	Licensed Practical Nurses	8,219	9,251	179,075	19.36	4
5	CNAs & Orderlies	21,875	23,923	243,779	10.19	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,834	2,109	21,767	10.32	9
10	Activity Assistants	1,865	2,143	18,635	8.70	10
11	Social Service Workers	11,200	12,413	142,322	11.47	11
12	Dietician					12
13	Food Service Supervisor	1,896	2,072	25,342	12.23	13
14	Head Cook	5,728	6,282	55,202	8.79	14
15	Cook Helpers/Assistants	6,219	7,050	61,356	8.70	15
16	Dishwashers					16
17	Maintenance Workers	3,708	4,230	36,966	8.74	17
18	Housekeepers	7,994	9,091	80,649	8.87	18
19	Laundry	2,646	2,798	24,345	8.70	19
20	Administrator	1,788	2,056	85,798	41.73	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	987	1,278	19,816	15.51	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					31
32	Other Health C: MDS,TRANS	3,529	3,947	57,210	14.49	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	84,100	93,704	$ 1,200,833 *	$ 12.82	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	$ 3,541	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	2,028	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	94	3,850	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	35	1,360	12-3	45
46	Other(specify) PSYCHIATRIC	MONTHLY	14,300	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	129	$ 61,079		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 HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY REESE	ADMINISTRATOR	0	$ 85,798
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 85,798

B. Administrative - Other

Description	Amount
HI CARE MANAGEMENT	$ 116,499
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 116,499

C. Professional Services

Vendor/Payee	Type	Amount
See Attached		$ 27,845
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 27,845

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,784
Unemployment Compensation Insurance	14,746
FICA Taxes	101,210
Employee Health Insurance	70,902
Employee Meals	6,277
Illinois Municipal Retirement Fund (IMRF)*	
401K Plan	4,101
TOTAL (agree to Schedule V, line 22, col.8)	$ 243,020

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	$
Advertising: Employee Recruitment	441
Health Care Worker Background Check	207
(Indicate # of checks performed 12)	
Patient Background Checks 10	160
IHCA	3,864
E Health Solutions	1,215
IL Secretary of State	405
Whiteside County	170
See attached	792
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,254

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Corp DON	3,458
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,458

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

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

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

Facility Name & ID Number TAMMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

XX. GENERAL INFORMATION:

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

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

(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. $ **587** 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. $ **293,676**
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. $ **6,277** 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? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

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

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

TOTAL FOOD PURCHASE	$	131,870
LESS SALES TAX	$	(1,319)
NET FOOD	$	130,551
TOTAL PATIENT CENSUS		24,155
MEALS PER DAY		3
TOTAL PATIENT MEALS		72,465
EMPLOYEES MEALS PER DAY		10
DAYS PER YEAR		366
TOTAL EMPLOYEE MEALS		3,660
TOTAL MEALS PER YEAR		76,125
COST PER MEAL	$	1.71
TOTAL EMPLOYEE MEAL COST	$	6,277

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

SCHEDULE XIX - DUES FEES SUBSCRIPTIONS AND PROMOTIONS

AICPA	Acctg Dues	$	85
AMEX	Card Dues	$	10
IDPR	License Fee	$	53
Dunham	Notary Fee	$	1
Medpass	Subscription	$	89
MES	Dues	$	171
Troxell	Bond	$	11
Sec of State	License Fee	$	372
Total		$	792

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SCHEDULE XIX - PROFESSIONAL SERVICES

Illin Tech	IT Services	$	5,723
Goldasich Architects	Architects	$	713
BPC	401K Admin	$	452
CCH	IT Services	$	56
Emdeon	REV System	$	177
Horwood Marcus	Legal	$	1,109
IVANS	IT Services	$	820
Krupnick Kagda	Acccounting	$	1,964
Margel Peddicord	Acccounting	$	80
MDI	IT Services	$	7,725
Pehlman Dold	Acccounting	$	889
Stratton,Giganti	Legal	$	2,524
TALX	Tax	$	643
Cole Taylor	Legal	$	470
Appraisal Research	Appraisal	$	4,500
Total		$	27,845

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SCHEDULE V, LINE 23 INSERVICE TRAINING AND EDUCATION

American Red Cross	$	307
CPE CPA	$	164
IHCA Training	$	475
Total	$	946

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SCHEDULE OF RENTAL EQUIPMENT

Item	Amount
Floor Mats	$ 4,331
Copiers	$ 4,294
Alarm System	$ 2,700
Beverage Cooler	$ 1,066
Dish Machine	$ 897
Totals	$ 13,288

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OTHER ADMIN STAFF TRANSPORTATION

EMPLOYEE	AMOUNT
TRANSPORT VAN FUEL AND REPAIRS	$ 7,882
TOTALS	$ 7,882