FOR BHF USE

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

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

I. IDPH License ID Number: 0035659

Facility Name: TAMMERLANE HLTH CARE CENTRE

Address: 3601 SIXTEENTH AVE (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
  - [ ] Charitable Corp.
  - [ ] Trust
  - IRS Exemption Code
- [X] PROPRIETARY
  - [ ] Individual
  - [ ] Partnership
  - [ ] Corporation
  - [X] "Sub-S" Corp.
  - [ ] Limited Liability Co.
  - [ ] Trust
  - [ ] Other
- [ ] GOVERNMENTAL
  - [ ] State
  - [ ] County
  - [ ] Other

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

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

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

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

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

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		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 Medicaid Recipient	3 Private Pay	4 Other	5 Total	
		Patient Days by Level of Care and Primary Source of Payment				
8	SNF					8
9	SNF/PED					9
10	ICF	22,302	729		23,031	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,302	729		23,031	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.14%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

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

I. On what date did you start providing long term care at this location?
Date started 07/01/1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/1989 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] 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: 12/31/2013 Fiscal Year: 12/31/2013

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

		Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	Operating Expenses	Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	155,608	11,064	4,956	171,628		171,628		171,628			1
2	Food Purchase		131,108		131,108	(12,403)	118,705	(1,311)	117,394			2
3	Housekeeping	92,627	14,369		106,996		106,996		106,996			3
4	Laundry	16,321	4,259		20,580		20,580		20,580			4
5	Heat and Other Utilities			45,561	45,561		45,561	(2,606)	42,955			5
6	Maintenance	37,946	5,742	19,369	63,057		63,057	6,713	69,770			6
7	Other (specify):* SCAVENGER			6,417	6,417		6,417		6,417			7
8	TOTAL General Services	302,502	166,542	76,303	545,347	(12,403)	532,944	2,796	535,740			8
	B. Health Care and Programs											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	674,284	37,554	27,922	739,760		739,760	3,564	743,324			10
10a	Therapy	8,087			8,087		8,087		8,087			10a
11	Activities	46,583	1,824		48,407		48,407		48,407			11
12	Social Services	127,095		2,300	129,395		129,395		129,395			12
13	CNA Training											13
14	Program Transportation			238	238		238		238			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	856,049	39,378	66,460	961,887		961,887	3,564	965,451			16
	C. General Administration											
17	Administrative	85,503		45,807	131,310		131,310	119,540	250,850			17
18	Directors Fees											18
19	Professional Services			11,858	11,858		11,858	7,381	19,239			19
20	Dues, Fees, Subscriptions & Promotions			11,139	11,139		11,139	627	11,766			20
21	Clerical & General Office Expenses	22,793	9,312	22,012	54,117		54,117	26,842	80,959			21
22	Employee Benefits & Payroll Taxes			171,015	171,015	12,403	183,418	43,661	227,079			22
23	Inservice Training & Education			1,986	1,986		1,986	660	2,646			23
24	Travel and Seminar							4,879	4,879			24
25	Other Admin. Staff Transportation			6,970	6,970		6,970		6,970			25
26	Insurance-Prop.Liab.Malpractice			19,312	19,312		19,312	19,337	38,649			26
27	Other (specify):*			29,473	29,473		29,473	(29,473)				27
28	TOTAL General Administration	108,296	9,312	319,572	437,180	12,403	449,583	193,454	643,037			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,266,847	215,232	462,335	1,944,414		1,944,414	199,814	2,144,228			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 HLTH CARE CENTRE #0035659 **Report Period Beginning:** 1/1/2013 **Ending:** 12/31/2013

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			11,393	11,393		11,393	27,875	39,268			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,513	4,513		4,513	82,651	87,164			32
33	Real Estate Taxes			9,587	9,587		9,587	1,388	10,975			33
34	Rent-Facility & Grounds			160,873	160,873		160,873	(160,873)				34
35	Rent-Equipment & Vehicles			11,340	11,340		11,340		11,340			35
36	Other (specify):*											36
37	**TOTAL Ownership**			197,706	197,706		197,706	(48,959)	148,747			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			178,000	178,000		178,000		178,000			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			178,000	178,000		178,000		178,000			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,266,847	215,232	838,041	2,320,120		2,320,120	150,855	2,470,975			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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,535)	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	3,787	30		9
10	Interest and Other Investment Income	(4,324)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,311)	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	(288)	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	(29,120)	27		24
25	Fund Raising, Advertising and Promotional	(226)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(65)	27		28
29	Other-Attach Schedule	15,121			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,961)		$	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)	171,816		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 171,816		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 150,855		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 HLTH CARE CENTRE

ID# 0035659

Report Period Beginning: 1/1/2013

Ending: 12/31/2013

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PRIOR YEAR INSURANCE ADJUSTMENT	$ 17,500	26	1
2	SAGE AGE MARKETING	(2,379)	19	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
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28				28
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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**	15,121		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

	Operating Expenses A. General Services	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)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,311)	0	0	0	0	0	0	0	0	0	0	(1,311)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,535)	1,929	0	0	0	0	0	0	0	0	0	(2,606)	5
6	Maintenance	0	6,713	0	0	0	0	0	0	0	0	0	6,713	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,846)	8,642	0	0	0	0	0	0	0	0	0	2,796	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	3,564	0	0	0	0	0	0	0	0	0	3,564	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	3,564	0	0	0	0	0	0	0	0	0	3,564	16
	C. General Administration													
17	Administrative	0	119,540	0	0	0	0	0	0	0	0	0	119,540	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(2,379)	9,587	173	0	0	0	0	0	0	0	0	7,381	19
20	Fees, Subscriptions & Promotions	(226)	853	0	0	0	0	0	0	0	0	0	627	20
21	Clerical & General Office Expenses	0	26,604	238	0	0	0	0	0	0	0	0	26,842	21
22	Employee Benefits & Payroll Taxes	0	43,661	0	0	0	0	0	0	0	0	0	43,661	22
23	Inservice Training & Education	0	660	0	0	0	0	0	0	0	0	0	660	23
24	Travel and Seminar	0	4,879	0	0	0	0	0	0	0	0	0	4,879	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	17,500	1,837	0	0	0	0	0	0	0	0	0	19,337	26
27	Other (specify):*	(29,473)	0	0	0	0	0	0	0	0	0	0	(29,473)	27
28	**TOTAL General Administration**	(14,578)	207,621	411	0	0	0	0	0	0	0	0	193,454	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(20,424)	219,827	411	0	0	0	0	0	0	0	0	199,814	29

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	3,787	0	1,137	22,951	0	0	0	0	0	0	0	27,875	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,324)	0	1,567	85,408	0	0	0	0	0	0	0	82,651	32
33	Real Estate Taxes	0	0	1,388	0	0	0	0	0	0	0	0	1,388	33
34	Rent-Facility & Grounds	0	0	0	(160,873)	0	0	0	0	0	0	0	(160,873)	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	(537)	0	4,092	(52,514)	0	0	0	0	0	0	0	(48,959)	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)	(20,961)	219,827	4,503	(52,514)	0	0	0	0	0	0	0	150,855	45

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT HEDGES	50	DOCTORS NURSING	SALEM	HI CARE MGMT	SPRINGFIELD	MANAGEMENT
WILLIAM IRVINE	50	EVERGREEN NURSING	EFFINGHAM	H&I PROPERTIES	SPRINGFIELD	REAL ESTATE
		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	$ 45,807	HI CARE MANAGEMENT		$	$ (45,807)	1
2	V	21	HOME OFFICE EXPENSE		HI CARE MANAGEMENT				2
3	V	6	MAINTENANCE		HI CARE MANAGEMENT		6,713	6,713	3
4	V	5	UTILITIES		HI CARE MANAGEMENT		1,929	1,929	4
5	V	10	NURSING		HI CARE MANAGEMENT		3,564	3,564	5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT		165,347	165,347	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		26,604	26,604	7
8	V	19	PROFESSIONAL SERVICES		HI CARE MANAGEMENT		9,587	9,587	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		853	853	9
10	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		660	660	10
11	V	24	TRAVEL		HI CARE MANAGEMENT		4,879	4,879	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		1,837	1,837	12
13	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT		43,661	43,661	13
14	Total			$ 45,807			$ 265,634	$ * 219,827	14

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES LLC		$ 1,137	$ 1,137	15
16	V	32	INTEREST		H&I PROPERTIES LLC		1,567	1,567	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES LLC		1,388	1,388	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES LLC		173	173	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES LLC		238	238	19
20	V				H&I PROPERTIES LLC				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			$			$ 4,503	$ * 4,503	39

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 160,873	H&I PROPERTIES (FACILITY)		$	$ (160,873)	15
16	V	30	DEPRECIATION		H&I PROPERTIES (FACILITY)		22,951	22,951	16
17	V	32	INTEREST		H&I PROPERTIES (FACILITY)		85,408	85,408	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			$ 160,873			$ 108,359	$ * (52,514)	39

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
					Compensation Received From Other	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	
	Name	Title	Function	Ownership Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50.00	152,233	8.498	21.24	SALARY	$ 41,066	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50.00	146,011	8.498	21.24	SALARY	39,387	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	11,377	8.498	21.24	SALARY	3,069	17-7	3
4	DEREK HEDGES	OPERATIONS	OPERATIONS	0.00	73,455	8.498	21.24	SALARY	19,815	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 103,337		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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization	HI CARE MANAGEMENT, 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	108,409	5	$ 31,601	$ 27,116	23,031	$ 6,713	1
2	5	UTILITIES	PER RESIDENT DAY	108,409	5	9,081		23,031	1,929	2
3	10	NURSING	PER RESIDENT DAY	108,409	5	16,777	16,777	23,031	3,564	3
4	17	ADMINISTRATION	PER RESIDENT DAY	108,409	5	778,304	778,304	23,031	165,347	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	108,409	5	125,226		23,031	26,604	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	108,409	5	45,127		23,031	9,587	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	108,409	5	4,017		23,031	853	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	108,409	5	3,109		23,031	660	8
9	24	TRAVEL	PER RESIDENT DAY	108,409	5	22,964		23,031	4,879	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	108,409	5	8,646		23,031	1,837	10
11	22	PAYROLL TAX AND BENEFIT:	PER RESIDENT DAY	108,409	5	205,518		23,031	43,661	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,250,370	$ 822,197		$ 265,634	25

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	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	9,940		70	1,567	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	444	5	8,803		70	1,388	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	444	5	1,095		70	173	4
5	21	OFFICE EXPENSE	PER LICENSE BED	444	5	1,508		70	238	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 28,559	$		$ 4,503	25

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 2/31/2013

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 22,951	$	1	$ 22,951	1
2	32	INTEREST	DIRECT	1	1	85,408		1	85,408	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					$ 108,359	$		$ 108,359	25

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	$ 1,258,423	08/15/2015	0.0650	$ 85,408	1
2	US BANK (H&I PROP)		X	MORTGAGE (OFFICE)		6/29/2005		32,443	06/29/2017	0.0425	1,567	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR		X	WORKING CAPITAL	INTEREST	REVOLV		65,000		PRIME+	4,513	6
7												7
8												8
9	TOTAL Facility Related				$13,205.00		$ 1,689,500	$ 1,355,866			$ 91,488	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	$ 1,355,866			$ 91,488	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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Item		Amount	Line
1. Real Estate Tax accrual used on 2012 report.	$	11,377	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.)	$	11,243	2
3. Under or (over) accrual (line 2 minus line 1).	$	(134)	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$	11,109	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.	$	10,975	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	Amount	Line
2008	9,872	8
2009	10,093	9
2010	11,348	10
2011	11,476	11
2012	11,243	12

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

NOTES:

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

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

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

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	11-10-329-006	NURSING HOME	$ 9,854.86	$ 9,854.86
2.	22-03.0-107-017	HOME OFFICE	$ 3,515.00	$ 554.21
3.	22-03.0-107-018	HOME OFFICE	$ 5,288.24	$ 833.79
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,658.10	$ 11,242.86

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 __________ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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	2	3	4	
	Use	Square Feet	Year Acquired	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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70		1998	1958	$ 887,968	$ 22,951	39	$ 22,951	$	$ 350,255	4
5											5
6	H&I										6
7	PROPERTIES										7
8	OFFC BLD			2005	41,448	1,137	39	1,137		7,683	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	69	27.5	69		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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	2006	$ 7,399	$ 268	27.5	$ 268	$	$ 2,027	37
38	PLUMBING	2007	9,763	651	15	651		4,367	38
39									39
40									40
41	DOORS	2008	6,830	248	27.5	248		1,374	41
42	BACKFLOW PLUMBING FIRE SPRINKLER	2009	5,889	214	27.5	214		954	42
43	FIRE ESCAPE STAIRCASE	2009	13,192	480	27.5	480		2,140	43
44	CONCRETE FOR SIDEWALK	2010	4,225	282	15	282		881	44
45	SIDEWALK REPLACEMENT	2011	3,229	215	15	215		457	45
46	DOORS	2012	3,134	80	39	80		150	46
47	WATER HEATER	2012	6,677	171	39	171		307	47
48	GENERATOR WORK	2013	10,075	162	39	162		162	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,207,515	$ 32,716		$ 32,716	$	$ 471,861	70

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 42,391	$ 168	$ 3,955	$ 3,787	10 YRS	$ 39,172	71
72	Current Year Purchases	16,200	2,597	2,597		5-10 YRS	2,568	72
73	Fully Depreciated Assets	55,643						73
74								74
75	TOTALS	$ 114,234	$ 2,765	$ 6,552	$ 3,787		$ 41,740	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)	$ 1,481,674	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,481	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 39,268	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,787	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 552,882	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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		70		$ 160,873			3
4	Additions							4
5								5
6								6
7	TOTAL		70		$ 160,873 **			7

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

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

10. Effective dates of current rental agreement:
Beginning ________
Ending ________

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

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

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

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

16. Rental Amount for movable equipment: $ 11,340 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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

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

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER CNA ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2013 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (15,000))	268,784		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,116		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	76,002		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 349,902	$	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	278,099		15
16	Equipment, at Historical Cost	153,515		16
17	Accumulated Depreciation (book methods)	(258,960)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	120,139		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits	17,500		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 310,293	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 660,195	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 225,806	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	65,000		29
30	Accrued Salaries Payable	54,629		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,067		31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,855		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Checks Outstanding	4,796		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 367,153	$	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)**	$ 367,153	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 293,042	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 660,195	$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 440,754	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 440,754	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(147,713)	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) ROUNDING	1	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (147,712)	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)**	$ 293,042	24 *

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,168,133	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,168,133	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***	4,324	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,324	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)**	$ 2,172,457	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	532,944	31
32	Health Care	961,887	32
33	General Administration	449,583	33
	B. Capital Expense		
34	Ownership	197,706	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	178,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,320,120	40
41	**Income before Income Taxes (line 30 minus line 40)****	(147,663)	41
42	**Income Taxes**	(50)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (147,713)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,062,278	44
45	Private Pay - Net Inpatient Revenue	105,855	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)	$ 2,168,133	49

* This must agree with page 4, line 45, column 4. TAX 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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,955	2,083	$ 61,045	$ 29.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,627	4,244	120,248	28.33	3
4	Licensed Practical Nurses	7,777	8,909	174,245	19.56	4
5	CNAs & Orderlies	22,891	25,442	261,272	10.27	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	995	934	8,087	8.66	8
9	Activity Director	1,814	2,117	22,140	10.46	9
10	Activity Assistants	2,380	2,719	24,443	8.99	10
11	Social Service Workers	9,295	10,717	127,095	11.86	11
12	Dietician					12
13	Food Service Supervisor	1,877	2,084	25,625	12.30	13
14	Head Cook	4,777	5,533	50,838	9.19	14
15	Cook Helpers/Assistants	7,812	8,682	79,145	9.12	15
16	Dishwashers					16
17	Maintenance Workers	3,619	4,220	37,946	8.99	17
18	Housekeepers	9,047	10,021	92,627	9.24	18
19	Laundry	1,618	1,875	16,321	8.70	19
20	Administrator	1,708	2,083	85,503	41.05	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,488	1,573	22,793	14.49	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,199	1,341	12,969	9.67	31
32	Other Health Ca MDS,Transport	1,741	2,321	44,505	19.17	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	85,620	96,898	$ 1,266,847 *	$ 13.07	34

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

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	$ 4,956	1-3	35
36	Medical Director	MONTHLY	36,000	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	23	3,972	10-3	38
39	Pharmacist Consultant	MONTHLY	2,262	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	96	4,788	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	28	1,100	12-3	45
46	Other(specify) PSYCHIATRIC	MONTHLY	16,900	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	146	$ 69,978		49

C. CONTRACT NURSES

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2013 Ending: 12/31/2013

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY REESE	ADMINISTRATOR	0	$ 85,503
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 85,503

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 45,807
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 45,807

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		19,239
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $5,000, attach copy of invoices.)		$ 19,239

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,858
Unemployment Compensation Insurance	16,825
FICA Taxes	108,067
Employee Health Insurance	62,294
Employee Meals	12,403
Illinois Municipal Retirement Fund (IMRF)*	
401K	3,632
TOTAL (agree to Schedule V, line 22, col.8)	$ 227,079

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 3,980
Advertising: Employee Recruitment	298
Health Care Worker Background Check	482
(Indicate # of checks performed 22)	
Patient Background Checks 14	
SEE ATTACHED SCHEDULE	7,006
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,766

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Corp Nurse Consultant	4,879
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,879

**See instructions.

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		$		$	$	$	$	$	$	$	$	$

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, $2898**

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

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **810** 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. $ **178,000**
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. $ **12,403** 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 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 12/31/13

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

TOTAL FOOD PURCHASE	$ 131,108
LESS SALES TAX	$ (1,311)
NET FOOD	$ 129,797
TOTAL PATIENT CENSUS	23,031
MEALS PER DAY	3
TOTAL PATIENT MEALS	69,093
EMPLOYEES MEALS PER DAY	20
DAYS PER YEAR	365
TOTAL EMPLOYEE MEALS	7,300
TOTAL MEALS PER YEAR	76,393
COST PER MEAL	$ 1.70
TOTAL EMPLOYEE MEAL COST	$ 12,403

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/13

SCHEDULE XIX - DUES FEES SUBSCRIPTIONS AND PROMOTIONS

Illinois Healthcare Assocation	Subscription	25
E-Health Data Services	Subscription	2,430
Illinois Healthcare Assocation	Dues	2,898
Sauk Valley Newspaper	Subscription	183
Illinois Secretary of State	Vehicle License	277
CLIA Laboratory Program	Permit	150
Whiteside County Health Department	Sanitation License	190
AICPA Member Services	Dues	119
Medpass Inc.	Subscription	88
MES of Illinois Inc	Dues	106
Sangamo Club	Dues	344
American Express	Membership	25
Illinois Nursing Home Assoc	Dues	21
Illinois CPA Society	Dues	85
Wall-St Journal	Subscription	65
Total		7,006

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/13

SCHEDULE XIX - PROFESSIONAL SERVICES

IIT/Sourcetech	Dietary Software & Menus	1,933
Smartlinx Solutions	Payroll Software	289
Sikich	Accounting	6,478
Cole Taylor Bank	Legal Fees	694
Colonial Acres	BOM	918
Evan Lloyd Architects	Building Plans	1,188
Sikich	Audit 401K	358
		11,858
TALX Corp	Tax Credit	993
CT Corp	Mo Agent	14
Kalin Healthcare Solutions	Nursing/MDS Consultant	650
Benefit Planning Consult	401K Third Party Admin	427
IHD Corp	Interviewing/Supervising	248
Dun & Bradstreet	Credit Rating	1,357
Sandberg Phoenix & Von Gontard	Legal Services	194
Stratton, Giganti, Stone, & Kopec	Legal Services	2,213
Duane Morris LLP	Legal Services	755
Sikich	Accounting	319
Cole Taylor	Loan Recording	53
Sikich	Accounting	158
		7,381
Total		19,239

SCHEDULE V, LINE 23 INSERVICE TRAINING AND EDUCATION

The Mandt System	Seminar	1,075
Fyr Fyter	In-Service	75
ARC	In-Service	836
MDI Achieve	Seminar	83
Illinois Nursing Home Assoc	Seminar	38
IHCA	Seminar	349
IHCA	Seminar	88
Illinois CFA Foundation	Seminar	61
Illinois Nursing Home Admin	Seminar	40
Total		2,646

TAMMERLANE HEALTHCARE CENTRE, INC.
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SCHEDULE OF RENTAL EQUIPMENT

Aramark	Door Mats	2,913
Electronic Equipment	Alarm System	2,700
Marlin Leasing Corp	Beverage Cooler	1,091
Performance Foods	Dish Washer	764
Banc of Am Leasing	Copier	2,767
Dell	Computers	319
Konica Minolta	Copier	786
TOTAL		11,340

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 12/31/13

OTHER ADMIN STAFF TRANSPORTATION

Transport VanFuel/Maintennce	1,264
Transport VanFuel/Maintennce	5,706
Total	6,970

TAMMERLANE HEALTHCARE CENTRE, INC
FACILITY ID 0035659
SCHEDULE VII
C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
REPORT PERIOD ENDING 12/31/2013

FACILITY ID	0046417	0046250	0035642	0046235	
	EVERGREEN	DOUGLAS	TRANSITIONS	DOCTORS	TOTAL
NAME	NURSING AND REHAB	NURSING AND REHAB	NURSING AND REHAB	NURSING AND REHAB	OTHER
ROBERT HEDGES	$ 55,544	$ 26,613	$ 18,678	$ 51,398	$ 152,233
WILLIAM IRVINE	$ 53,274	$ 25,525	$ 17,914	$ 49,298	$ 146,011
MARTHA IRVINE	$ 4,151	$ 1,989	$ 1,396	$ 3,841	$ 11,377
DEREK HEDGES	$ 26,801	$ 12,841	$ 9,012	$ 24,801	$ 73,455
	$ 139,770	$ 66,968	$ 47,000	$ 129,338	$ 383,076