FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

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

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2014 to 10/31/2014 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider

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

Paid Preparer

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

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	21,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	21,280	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	18,722	612		19,334	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,722	612		19,334	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.86%

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 [ ] NO [ ]

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

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	138,553	9,422	3,660	151,635		151,635		151,635			1
2	Food Purchase		114,980		114,980	(10,858)	104,122	(540)	103,582			2
3	Housekeeping	80,655	13,101		93,756		93,756		93,756			3
4	Laundry	15,056	2,816		17,872		17,872		17,872			4
5	Heat and Other Utilities			40,545	40,545		40,545	(2,862)	37,683			5
6	Maintenance	34,081	3,483	12,958	50,522		50,522	1,798	52,320			6
7	Other (specify):* Scavenger			6,404	6,404		6,404		6,404			7
8	**TOTAL General Services**	268,345	143,802	63,567	475,714	(10,858)	464,856	(1,604)	463,252			8
	B. Health Care and Programs											
9	Medical Director			29,323	29,323		29,323		29,323			9
10	Nursing and Medical Records	567,639	15,395	19,449	602,483		602,483		602,483			10
10a	Therapy											10a
11	Activities	45,692	973		46,665		46,665		46,665			11
12	Social Services	119,485		593	120,078		120,078		120,078			12
13	CNA Training											13
14	Program Transportation			250	250		250		250			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	732,816	16,368	49,615	798,799		798,799		798,799			16
	C. General Administration											
17	Administrative	94,854			94,854		94,854	128,667	223,521			17
18	Directors Fees											18
19	Professional Services			16,895	16,895		16,895	4,047	20,942			19
20	Dues, Fees, Subscriptions & Promotions			9,888	9,888		9,888	307	10,195			20
21	Clerical & General Office Expenses	22,111	12,027	32,382	66,520		66,520	11,642	78,162			21
22	Employee Benefits & Payroll Taxes			155,694	155,694	10,858	166,552	33,684	200,236			22
23	Inservice Training & Education			1,431	1,431		1,431	481	1,912			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			9,761	9,761		9,761	2,795	12,556			25
26	Insurance-Prop.Liab.Malpractice			35,804	35,804		35,804	1,484	37,288			26
27	Other (specify):*			31,711	31,711		31,711	(31,711)				27
28	**TOTAL General Administration**	116,965	12,027	293,566	422,558	10,858	433,416	151,396	584,812			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,118,126	172,197	406,748	1,697,071		1,697,071	149,792	1,846,863			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: 1/1/2014 Ending: 10/31/2014

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			13,703	13,703		13,703	23,764	37,467			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,890	4,890		4,890	81,845	86,735			32
33	Real Estate Taxes			8,452	8,452		8,452	1,231	9,683			33
34	Rent-Facility & Grounds			131,227	131,227		131,227	(131,227)				34
35	Rent-Equipment & Vehicles			5,912	5,912		5,912		5,912			35
36	Other (specify):*											36
37	**TOTAL Ownership**			164,184	164,184		164,184	(24,387)	139,797			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		16,431		16,431		16,431		16,431			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			149,091	149,091		149,091		149,091			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		16,431	149,091	165,522		165,522		165,522			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,118,126	188,628	720,023	2,026,777		2,026,777	125,405	2,152,182			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: 1/1/2014 Ending: 10/31/2014

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(4,937)	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				9
10	Interest and Other Investment Income	(72)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,156)	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	(338)	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	(22,349)	27		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,543)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (37,395)		$	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)			34
35	Other- Attach Schedule	162,800		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 162,800		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 125,405		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: 1/1/2014

Ending: 10/31/2014

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Adveretising	$ (135)	20	1
2	Casualty loss	(9,024)	27	2
3	Employee Meal Reimbursement	616	2	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,543)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 **Report Period Beginning:** 1/1/2014 **Ending:** 10/31/2014

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(540)	0	0	0	0	0	0	0	0	0	0	(540)	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	(4,937)	2,075	0	0	0	0	0	0	0	0	0	(2,862)	5
6	Maintenance	0	1,798	0	0	0	0	0	0	0	0	0	1,798	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,477)	3,873	0	0	0	0	0	0	0	0	0	(1,604)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	128,667	0	0	0	0	0	0	0	0	0	128,667	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,494	553	0	0	0	0	0	0	0	0	4,047	19
20	Fees, Subscriptions & Promotions	(135)	442	0	0	0	0	0	0	0	0	0	307	20
21	Clerical & General Office Expenses	0	11,460	182	0	0	0	0	0	0	0	0	11,642	21
22	Employee Benefits & Payroll Taxes	0	33,684	0	0	0	0	0	0	0	0	0	33,684	22
23	Inservice Training & Education	0	481	0	0	0	0	0	0	0	0	0	481	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	2,795	0	0	0	0	0	0	0	0	0	2,795	25
26	Insurance-Prop.Liab.Malpractice	0	1,484	0	0	0	0	0	0	0	0	0	1,484	26
27	Other (specify):*	(31,711)	0	0	0	0	0	0	0	0	0	0	(31,711)	27
28	**TOTAL General Administration**	(31,846)	182,507	735	0	0	0	0	0	0	0	0	151,396	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(37,323)	186,380	735	0	0	0	0	0	0	0	0	149,792	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 **Report Period Beginning:** 1/1/2014 **Ending:** 10/31/2014

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	989	22,775	0	0	0	0	0	0	0	23,764	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(72)	0	1,180	80,737	0	0	0	0	0	0	0	81,845	32
33	Real Estate Taxes	0	0	1,231	0	0	0	0	0	0	0	0	1,231	33
34	Rent-Facility & Grounds	0	0	0	(131,227)	0	0	0	0	0	0	0	(131,227)	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**	(72)	0	3,400	(27,715)	0	0	0	0	0	0	0	(24,387)	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)**	(37,395)	186,380	4,135	(27,715)	0	0	0	0	0	0	0	125,405	45

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ROBERT HEDGES	50	DOCTORS NURSING	SALEM	HI CARE MGMT	City	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	SPRINGFIELD	

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	$	HI CARE MANAGEMENT		$	$	1
2	V	21	HOME OFFICE EXPENSE		HI CARE MANAGEMENT				2
3	V	6	MAINTENANCE		HI CARE MANAGEMENT		1,798	1,798	3
4	V	5	UTILITIES		HI CARE MANAGEMENT		2,075	2,075	4
5	V	10	NURSING		HI CARE MANAGEMENT				5
6	V	17	ADMINISTRATION		HI CARE MANAGEMENT		128,667	128,667	6
7	V	21	OFFICE EXPENSE		HI CARE MANAGEMENT		11,460	11,460	7
8	V	19	PROFESSIONAL SERVICES		HI CARE MANAGEMENT		3,494	3,494	8
9	V	20	DUES AND SUBSCRIPTIONS		HI CARE MANAGEMENT		442	442	9
10	V	23	TRAINING AND EDUCATION		HI CARE MANAGEMENT		481	481	10
11	V	25	TRAVEL		HI CARE MANAGEMENT		2,795	2,795	11
12	V	26	LIABILITY INSURANCE		HI CARE MANAGEMENT		1,484	1,484	12
13	V	22	PAYROLL TAX AND BENEFITS		HI CARE MANAGEMENT		33,684	33,684	13
14	Total			$			$ 186,380	$ * 186,380	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: 1/1/2014 Ending: 10/31/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	DEPRECIATION	$	H&I PROPERTIES LLC		$ 989	$ 989	15
16	V	32	INTEREST		H&I PROPERTIES LLC		1,180	1,180	16
17	V	33	REAL ESTATE TAXES		H&I PROPERTIES LLC		1,231	1,231	17
18	V	19	PROFESSIONAL FEES		H&I PROPERTIES LLC		553	553	18
19	V	21	OFFICE EXPENSE		H&I PROPERTIES LLC		182	182	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			$			$ 4,135	$ * 4,135	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: 1/1/2014 Ending: 10/31/2014

VII. RELATED PARTIES (continued)

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

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

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 131,227	H&I PROPERTIES (FACILITY)		$	$ (131,227)	15
16	V	30	DEPRECIATION		H&I PROPERTIES (FACILITY)		22,775	22,775	16
17	V	32	INTEREST		H&I PROPERTIES (FACILITY)		80,737	80,737	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			$ 131,227			$ 103,512	$ * (27,715)	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: 1/1/2014 Ending: 10/31/2014

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES	PRESIDENT	OFFICE MGMT	50.00	122,713	7.45	0.19	SALARY	$ 28,088	17-7	1
2	WILLIAM IRVINE	VP	OFFICE MGMT	50.00	115,702	7.45	0.19	SALARY	26,483	17-7	2
3	MARTHA IRVINE	BOOKKEEPING	BOOKKEEPING	0.00	11,755	7.45	0.19	SALARY	2,691	17-7	3
4	DEREK HEDGES	OPERATIONS	OPERATIONS	0.00	77,688	7.45	0.19	SALARY	17,782	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 75,044		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: 1/1/2014 Ending: 0/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: HI CARE MANAGEMENT, 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	103,802	5	$ 9,651	$ 4,449	19,334	$ 1,798	1
2	5	UTILITIES	PER RESIDENT DAY	103,802	5	11,142		19,334	2,075	2
3	10	NURSING	PER RESIDENT DAY	103,802	5			19,334	0	3
4	17	ADMINISTRATION	PER RESIDENT DAY	103,802	5	690,800	690,800	19,334	128,667	4
5	21	OFFICE EXPENSE	PER RESIDENT DAY	103,802	5	61,526		19,334	11,460	5
6	19	PROFESSIONAL SERVICES	PER RESIDENT DAY	103,802	5	18,760		19,334	3,494	6
7	20	DUES AND SUBSCRIPTIONS	PER RESIDENT DAY	103,802	5	2,373		19,334	442	7
8	23	TRAINING AND EDUCATION	PER RESIDENT DAY	103,802	5	2,580		19,334	481	8
9	25	TRAVEL	PER RESIDENT DAY	103,802	5	15,007		19,334	2,795	9
10	26	LIABILITY INSURANCE	PER RESIDENT DAY	103,802	5	7,969		19,334	1,484	10
11	22	PAYROLL TAX AND BENEFIT	PER RESIDENT DAY	103,802	5	180,848		19,334	33,684	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,000,656	$ 695,249		$ 186,380	25

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 0/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

Name of Related Organization: H&I PROPERTIES-HOME OFFICE
Street Address: 1625 S 6TH 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	423	5	$ 7,214	$	58	$ 989	1
2	32	INTEREST	PER LICENSE BED	423	5	8,604		58	1,180	2
3	33	REAL ESTATE TAXES	PER LICENSE BED	423	5	8,975		58	1,231	3
4	19	PROFESSIONAL FEES	PER LICENSE BED	423	5	4,030		58	553	4
5	21	OFFICE EXPENSE	PER LICENSE BED	423	5	1,329		58	182	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 30,152	$		$ 4,135	25

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 0/31/2014

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 22,775	$	1	$ 22,775	1
2	32	INTEREST	DIRECT	1	1	80,737		1	80,737	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					$ 103,512	$		$ 103,512	25

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	COLE TAYLOR (H&I PROP)		X	MORTGAGE (FACILITY)	$13,205.00	8/3/2005	$ 1,689,500	$	08/15/2015	0.0650	$ 80,737	1
2	US BANK (H&I PROP)		X	MORTGAGE (OFFICE)		6/29/2005			06/29/2017	0.0425	1,180	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR		X	WORKING CAPITAL	INTEREST	REVOLV				PRIME+	4,890	6
7												7
8												8
9	TOTAL Facility Related				$13,205.00		$ 1,689,500	$			$ 86,807	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	$			$ 86,807	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: 1/1/2014 Ending: 10/31/2014

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 11,109	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.)		$ 11,217	2
3. Under or (over) accrual (line 2 minus line 1).		$ 108	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 9,575	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.		$ 9,683	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	10,093	8
	2010	11,348	9
	2011	11,476	10
	2012	11,243	11
	2013	11,217	12

Tax for 1/1 thru 10/31

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2013	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

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

2013 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2013 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2013.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-10-329-006	NURSING HOME	$ 9,985.96	$ 9,985.96
2.	22-03.0-107-017	HOME OFFICE	$ 5,391.38	$ 739.24
3.	22-03.0-107-018	HOME OFFICE	$ 3,583.56	$ 491.36
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 18,960.90	$ 11,216.56

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70		1998	1958	$ 887,968	$ 22,775	39	$ 22,775	$	$ 373,030	4
5											5
6	H&I										6
7	PROPERTIES										7
8	OFFC BLD			2005	41,448	989	39	989			8
	Improvement Type**										
9	IMPROVEMENTS			1992	14,227	452	31.5	452		9,608	9
10	IMPROVEMENTS			1993	3,670	94	39	94		1,900	10
11	IMPROVEMENTS			1994	7,850	201	39	201		3,841	11
12	PLUMBING WORK			1995	3,302	85	39	85		1,583	12
13	INSTALLED BOILER TANK			1995	600	15	39	15		280	13
14	INSTALLED 2 PUMPS			1995	2,289	59	39	59		1,094	14
15	PLUMBING WORK			1995	10,752	276	39	276		5,095	15
16	DOORS			1995	2,094	54	39	54		983	16
17	TWO DOORS			1995	1,055	27	39	27		489	17
18	INSTALLED ATTIC FAN & DUCT			1995	2,412	62	39	62		1,119	18
19	PARKING LOT			1995	32,070		15			32,070	19
20	WALL PROTECTOR			1997	3,328	85	39	85		1,428	20
21	SEPTIC FIELD PLUMBING WORK			1998	25,965	666	39	666		10,073	21
22	2 NEW WATER HEATERS			1999	12,083	310	39	310		4,507	22
23	CIRCUIT BREAKER PANELS			1999	2,230	57	39	57		829	23
24	ELECTRICAL WORK			1999	2,374	61	39	61		887	24
25	BREAKER PANELS			2001	2,542	92	27.5	92		1,154	25
26	BLACKTOP			2001	11,161	744	15	744		9,331	26
27	BOILER			2003	9,911	360	37.5	360		3,615	27
28	WINDOWS			2005	1,832	69	27.5	69		546	28
29	MAIN BREAKER PANEL			2005	13,684	498	27.5	498		4,047	29
30	ALARM SYSTEM			2005	20,688	752	27.5	752		6,047	30
31	CONCRETE WALKWAY			2005	1,800	120	15	120		985	31
32	FIRE SYSTEM			2005	1,769	63	27.5	63		510	32
33	OUTDOOR WIRELESS MONITORING SYSTEM			2006	7,405	269	27.5	269		2,029	33
34	ELECTRICAL WORK			2006	2,379	87	27.5	87		656	34
35	WANDER GUARD SYSTEM			2006	5,893	214	27.5	214		1,614	35
36	DOORS			2006	2,321	85	27.5	85		641	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: 1/1/2014 Ending: 10/31/2014

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WATER HEATER	2006	$ 7,399	$ 268	27.5	$ 268	$	$ 2,295	37
38	PLUMBING	2007	9,763	651	15	651		5,018	38
39									39
40									40
41	DOORS	2008	6,830	248	27.5	248		1,622	41
42	BACKFLOW PLUMBING FIRE SPRINKLER	2009	5,889	214	27.5	214		1,168	42
43	FIRE ESCAPE STAIRCASE	2009	13,192	480	27.5	480		2,620	43
44	CONCRETE FOR SIDEWALK	2010	4,225	282	15	282		1,163	44
45	SIDEWALK REPLACEMENT	2011	3,229	215	15	215		672	45
46	DOORS	2012	3,134	80	39	80		230	46
47	WATER HEATER	2012	6,677	171	39	171		478	47
48	GENERATOR WORK	2013	10,075	258	39	258		420	48
49									49
50	DOORS	2014	5,158	28	39	28		28	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)		$ 1,212,673	$ 32,516		$ 32,516	$	$ 495,705	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: 1/1/2014 Ending: 10/31/2014

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 58,591	$ 4,468	$ 4,468	$	5-10 YRS	$ 46,208	71
72	Current Year Purchases	3,380	483	483		5-10 YRS	483	72
73	Fully Depreciated Assets	55,643					55,643	73
74								74
75	TOTALS	$ 117,614	$ 4,951	$ 4,951	$		$ 102,334	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)	$ 1,490,212	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,467	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 37,467	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 637,320	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: 1/1/2014 Ending: 10/31/2014

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: H&I PROPERTIES
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		70		$ 131,227			3
4	Additions							4
5								5
6								6
7	TOTAL		70		$ 131,227 **			7

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

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

10. Effective dates of current rental agreement:
    Beginning
    Ending

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

	Fiscal Year Ending	Annual Rent
12.	/2015	$
13.	/2016	$
14.	/2017	$

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

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 5,912 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: 1/1/2014 Ending: 10/31/2014

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		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	39-2	# of prescrpts				16,431		16,431	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			$		$	$ 16,431		$ 16,431	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: 1/1/2014 Ending: 10/31/2014

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 10/31/2014 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 16,385	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 15,000)	29,190		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,827		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 50,402	$	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	283,257		15
16	Equipment, at Historical Cost	156,895		16
17	Accumulated Depreciation (book methods)	(272,663)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	61,813		21
22	Other Long-Term Assets (spe **Insurance deposit**	17,500		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 246,802	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 297,204	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 40,557	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)	1,241		31
32	Accrued Real Estate Taxes(Sch.IX-B)	8,321		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	**Medicaid Advance**	39,823		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 89,942	$	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)**	$ 89,942	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 207,262	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 297,204	$	48

***(See instructions.)**

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 293,042	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 293,042	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(174,278)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Writeoff intercompany payable**	88,498	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (85,780)	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)**	$ 207,262	24 *

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,852,427	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,852,427	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***	72	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 72	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,852,499	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	464,856	31
32	Health Care	798,799	32
33	General Administration	433,416	33
	B. Capital Expense		
34	Ownership	164,184	34
	C. Ancillary Expense		
35	Special Cost Centers	16,431	35
36	Provider Participation Fee	149,091	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,026,777	40
41	**Income before Income Taxes (line 30 minus line 40)****	(174,278)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (174,278)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,773,631	44
45	Private Pay - Net Inpatient Revenue	78,796	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)	$ 1,852,427	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: 1/1/2014 Ending: 10/31/2014

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,457	1,778	$ 50,332	$ 28.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,204	3,518	92,672	26.34	3
4	Licensed Practical Nurses	6,597	7,965	148,725	18.67	4
5	CNAs & Orderlies	19,941	22,508	215,346	9.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,535	1,879	18,822	10.02	9
10	Activity Assistants	3,048	3,246	26,870	8.28	10
11	Social Service Workers	8,780	10,690	119,485	11.18	11
12	Dietician					12
13	Food Service Supervisor	1,378	1,861	21,859	11.75	13
14	Head Cook	4,590	5,671	49,889	8.80	14
15	Cook Helpers/Assistants	6,603	7,621	66,805	8.77	15
16	Dishwashers					16
17	Maintenance Workers	3,193	3,910	34,081	8.72	17
18	Housekeepers	7,794	9,239	80,655	8.73	18
19	Laundry	1,465	1,702	15,056	8.85	19
20	Administrator	1,793	2,540	94,854	37.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,597	1,708	22,111	12.95	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	1,667	2,062	18,223	8.84	31
32	Other Health C: MDS,TRANSPOR	1,643	2,144	42,341	19.75	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	76,285	90,042	$ 1,118,126 *	$ 12.42	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	$ 3,660	1-3	35
36	Medical Director	MONTHLY	29,323	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	0		10-3	38
39	Pharmacist Consultant	MONTHLY	1,911	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	75	4,538	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	40	593	12-3	45
46	Other(specify) Psychiatric	MONTHLY	13,000	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	115	$ 53,025		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 HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY REESE	ADMINISTRATOR	0	$ 70,795
ANGELA MEHLBRECH	ADMINISTRATOR	0	24,059
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 94,854

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE ATTACHED SCHEDULE		20,942
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 20,942

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,581
Unemployment Compensation Insurance	18,132
FICA Taxes	94,855
Employee Health Insurance	42,501
Employee Meals	10,858
Illinois Municipal Retirement Fund (IMRF)*	
401K	4,309
TOTAL (agree to Schedule V, line 22, col.8)	$ 200,236

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	$
Advertising: Employee Recruitment	2,560
Health Care Worker Background Check	395
(Indicate # of checks performed 9)	
Patient Background Checks 20	560
SEE ATTACHED SCHEDULE	6,680
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,195

G. Schedule of Travel and Seminar**

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

**See instructions.

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

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

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

Facility Name & ID Number TAMMERLANE HLTH CARE CENTRE # 0035659 Report Period Beginning: 1/1/2014 Ending: 10/31/2014

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $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? **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. $ **577** 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. $ **149,091**
This amount is to be recorded on line 42 of Schedule V.

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **75**
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **NA**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

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

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

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
COST REPORT PERIOD ENDING 10/31/14
FACILITY ID 0035659

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

TOTAL FOOD PURCHASE	$	115,596
LESS SALES TAX	$	(1,156)
NET FOOD	$	114,440
TOTAL PATIENT CENSUS		19,334
MEALS PER DAY		3
TOTAL PATIENT MEALS		58,002
EMPLOYEES MEALS PER DAY		20
DAYS PER YEAR		304
TOTAL EMPLOYEE MEALS		6,080
TOTAL MEALS PER YEAR		64,082
COST PER MEAL	$	1.79
TOTAL EMPLOYEE MEAL COST	$	10,858

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 10/31/14

SCHEDULE XIX - DUES FEES SUBSCRIPTIONS AND PROMOTIONS

Illinois Healthcare Assocation	Dues	3,864
E-Health Data Services	Subscription	1,822
Sauk Valley Newspaper	Subscription	16
Illinois Secretary of State	Vehicle License	201
Illinois Fire Marshall	Permit	100
Whiteside County Health Departr	Foodservice License	135
AICPA Member Services	Dues	79
Medpass Inc.	Subscription	77
MES of Illinois Inc	Dues	100
SHRM	Membership	34
Illinois CPA Society	Dues	76
Wall-St Journal	Subscription	176
Total		6,680

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 10/31/14

SCHEDULE XIX - PROFESSIONAL SERVICES

IIT/Sourcetech	Dietary Software & Menus	1,723
Smartlinx Solutions	Payroll Software	2,203
Sikich	Accounting	6,124
Matrix	Software	5,040
Cole Taylor	Bank Audit	2,236
TALX Corp	Tax Credit	908
CT Corp	Mo Agent	11
Wage Works	Compliance	69
Dun & Bradstreet	Credit Rating	141
BPC	401K Admin	267
Cole Taylor	Legal	553
Stratton, Giganti	Legal	1,480
KBA	Health Consultant	187
Total		20,942

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 10/31/14

SCHEDULE OF RENTAL EQUIPMENT

Aramark	Door Mats	$ 737
Electronic Equipment	Alarm System	$ 2,250
Marlin Leasing Corp	Beverage Cooler	$ 980
Banc of Am Leasing	Copier	$ 1,489
Dell	Computers	$ 456
TOTAL		$ 5,912

TAMMERLANE HEALTHCARE CENTRE, INC
FACILITY ID 0035659
SCHEDULE VII
C. STATEMENT OF COMPENSATION FROM OTHER NUSING HOMES
REPORT PERIOD ENDING 10/31/2014

FACILITY ID	0046417	0046250	0035642	0035659	
	EVERGREEN	DOUGLAS	TRANSITIONS	DOCTORS	TOTAL
NAME	NURSING AND REHAB	NURSING AND REHAB	NURSING AND REHAB	HEALTHCARE CENTRE	OTHER
ROBERT HEDGES	$ 47,051	$ 20,346	$ 13,437	$ 41,879	$ 122,713
WILLIAM IRVINE	$ 44,363	$ 19,184	$ 12,669	$ 39,486	$ 115,702
MARTHA IRVINE	$ 4,507	$ 1,949	$ 1,287	$ 4,012	$ 11,755
DEREK HEDGES	$ 29,787	$ 12,881	$ 8,507	$ 26,513	$ 77,688
	$ 125,708	$ 54,360	$ 35,900	$ 111,890	$ 327,858

TAMMERLANE HEALTHCARE CENTRE, INC.
FACILITY ID 0035659
SCHEDULES
COST REPORT PERIOD ENDING 10/31/14

OTHER ADMIN STAFF TRANSPORTATION

Transport VanFuel/Maintennce	9,761
Corp Travel	2,795
Total	12,556