

		FOR BHF USE					

LL1

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

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: 0047209

Facility Name: East Bank Center, LLC

Address: 6131 Park Ridge Road Loves Park 61111
Number City Zip Code

County: Winnebago

Telephone Number: (815) 633-6810 Fax # (815) 633-5095

HFS ID Number:

Date of Initial License for Current Owners: 6/15/05

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "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: James Dale Telephone Number: (815) 637-2200
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/12 to 12/31/12 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) _____
(Type or Print Name) _____
(Title) _____

Paid
Preparer

(Signed) _____
(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 East Bank Center, LLC# 0047209 Report Period Beginning: 01/01/12 Ending: 12/31/12

III. STATISTICAL DATA

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

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>54</u>	Skilled (SNF)	<u>54</u>	<u>19,764</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>54</u>	TOTALS	<u>54</u>	<u>19,764</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>18</u>	<u>4,034</u>	<u>7,965</u>	<u>12,017</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>18</u>	<u>4,034</u>	<u>7,965</u>	<u>12,017</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 60.80%

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?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/15/2005

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 06/15/2005NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number
of beds certified 54 and days of care provided 7,965Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

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

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	174,304	7,072	18,898	200,274		200,274		200,274			1
2	Food Purchase		121,688		121,688		121,688		121,688			2
3	Housekeeping	133,543	12,103	8,220	153,866		153,866		153,866			3
4	Laundry		6,157	300	6,457		6,457		6,457			4
5	Heat and Other Utilities			87,118	87,118		87,118	(14,237)	72,881			5
6	Maintenance	18,725		58,487	77,212		77,212		77,212			6
7	Other (specify):*											7
8	TOTAL General Services	326,572	147,020	173,023	646,615		646,615	(14,237)	632,378			8
	B. Health Care and Programs											
9	Medical Director			28,709	28,709		28,709		28,709			9
10	Nursing and Medical Records	1,392,165	178,141	57,441	1,627,747		1,627,747		1,627,747			10
10a	Therapy	327,208			327,208		327,208		327,208			10a
11	Activities	35,484	1,308	1,182	37,974		37,974		37,974			11
12	Social Services			3,810	3,810		3,810		3,810			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,754,857	179,449	91,142	2,025,448		2,025,448		2,025,448			16
	C. General Administration											
17	Administrative	228,632			228,632		228,632		228,632			17
18	Directors Fees											18
19	Professional Services			41,544	41,544		41,544		41,544			19
20	Dues, Fees, Subscriptions & Promotions			10,675	10,675		10,675		10,675			20
21	Clerical & General Office Expenses	114,091	12,086	113,746	239,923		239,923		239,923			21
22	Employee Benefits & Payroll Taxes			408,631	408,631		408,631		408,631			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,699	3,699		3,699		3,699			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			101,164	101,164		101,164		101,164			26
27	Other (specify):*	87,094		39,988	127,082		127,082	(127,082)				27
28	TOTAL General Administration	429,817	12,086	719,447	1,161,350		1,161,350	(127,082)	1,034,268			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,511,246	338,555	983,612	3,833,413		3,833,413	(141,319)	3,692,094			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			188,224	188,224		188,224		188,224			30
31	Amortization of Pre-Op. & Org.			31,078	31,078		31,078		31,078			31
32	Interest			504,932	504,932		504,932		504,932			32
33	Real Estate Taxes			25,842	25,842		25,842		25,842			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			750,076	750,076		750,076		750,076			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,302,172	1,302,172		1,302,172		1,302,172			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,646	29,646		29,646		29,646			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,331,818	1,331,818		1,331,818		1,331,818			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,511,246	338,555	3,065,506	5,915,307		5,915,307	(141,319)	5,773,988			45

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

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.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	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	(14,237)	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				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				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				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,687)	27		24
25	Fund Raising, Advertising and Promotional	(100,395)	27		25
	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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (141,319)		\$	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	2	
		Amount	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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (141,319)		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	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39	Outpatient Services		X	41,259	39	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		X	41,536	39	42
43	Prescription Drugs		X	579,297	39	43
44	Illinois Bed Tax		X	29,646	42	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 691,738		47

East Bank Center, LLC

Report Period Beginning: ID# 0047209
Ending: 01/01/12
12/31/12

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
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	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number East Bank Center, LLC # 0047209 Report Period Beginning: 01/01/12 Ending: 12/31/12

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	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	(14,237)	0	0	0	0	0	0	0	0	0	0	(14,237)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(14,237)	0	0	0	0	0	0	0	0	0	0	(14,237)	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	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(127,082)	0	0	0	0	0	0	0	0	0	0	(127,082)	27
28	TOTAL General Administration	(127,082)	0	0	0	0	0	0	0	0	0	0	(127,082)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(141,319)	0	0	0	0	0	0	0	0	0	0	(141,319)	29

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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)	(141,319)	0	0	0	0	0	0	0	0	0	0	(141,319)	45

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
Attached Schedule		Home Bridge Center	Belvidere	Advanced Therapy So	Rockford	Therapy
				Transitions Hospice	Huntley	Hospice
				Advantage Medical Ec	Huntley	DME and Supplies
				Axis Management	Huntley	Management Svcs

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	39	Therapy Services	\$ 640,080	Advanced Therapy Solutions		\$ 640,080	\$	1
2	V								2
3	V	10	DME and Supplies	138,434	Advantage Medical Equipment		138,434		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 778,514			\$ 778,514	\$ *	14

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edna Atanacio	Admiss/Disch Coord	Admiss/clerical	0.01	0	40	100.00	Wages	\$ 74,345	21-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 74,345		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

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	Inland Bank / Amresco		X	Mortgage	\$31,842.00	6/17/05	\$ 3,941,429	\$ 3,535,632	2013	7.5500	\$ 255,461	1	
2	Aadiyat Business Resources		X	Operations	\$5,075.00	10/31/11	100,000	46,453	10/31/13	19.0000	14,276	2	
3	Advanced Management Co.	X		Operations	None		159,463	38,011	N/A			3	
4	S. Parekh	X		Operations	None		70,000	70,000	N/A			4	
5	J. Palazzo	X		Operations	None		8,751	8,751	N/A			5	
	Working Capital												
6	Midwest Business Credit		X	Operating LOC	Interest only	2008	850,000	863,776	2013	floating	213,814	6	
7	Other misc interest		X	Working Capital	N/A	var					21,381	7	
8												8	
9	TOTAL Facility Related				\$36,917.00		\$ 5,129,643	\$ 4,562,623			\$ 504,932	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 5,129,643	\$ 4,562,623			\$ 504,932	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.)

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.			
1. Real Estate Tax accrual used on 2011 report.		\$	26,275	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.)		\$	25,423	2	
3. Under or (over) accrual (line 2 minus line 1).		\$	(852)	3	
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	26,694	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.		\$	25,842	7	
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	21,648	8	
		2008	22,988	9	
		2009	23,895	10	
		2010	25,024	11	
		2011	25,423	12	
				13	FOR BHF USE ONLY
				13	FROM R. E. TAX STATEMENT FOR 2011 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME East Bank Center, LLC COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0047209

CONTACT PERSON REGARDING THIS REPORT James Dale

TELEPHONE (815) 637-2200 FAX #: (815) 637-2900

A. Summary of Real Estate Tax Cost

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

(A)		(B)	(C)	(D)
Tax Index Number		Property Description	Total Tax	Tax Applicable to Nursing Home
1.	11-01-252-012	Facility	\$ 24,529.00	\$ 24,529.00
2.	11-01-177-016	Land	\$ 894.00	\$ 894.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 25,423.00	\$ 25,423.00

B. Real Estate Tax Cost Allocations

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

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

C. **Tax Bills**

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

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,000

B. General Construction Type: Exterior Brick Frame Steel

Number of Stories 1

C. Does the Operating Entity?

☒ (a) Own the Facility

☐ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Rehab Facility	15,000	2005	\$ 50,000	1
2					2
3	TOTALS	15,000		\$ 50,000	3

Facility Name & ID Number East Bank Center, LLC

0047209

Report Period Beginning:

01/01/12

Ending:

12/31/12

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	54		2005		\$ 844,430	\$ 21,652	39	\$ 21,652		\$ 164,195
5										
6										
7										
8										
	Improvement Type**									
9	Building Wings A, B, C, & Front									
10	Insurance			2006	7,780	199	39	199		1,279
11	Overhead& Fee			2006	79,134	2029	39	2029		13,019
12	General Requirements			2006	86,308	2213	39	2213		14,200
13	Demolition			2006	33,784	866	39	866		5,557
14	Concrete			2006	14,818	380	39	380		2,438
15	Masonry			2006	33,589	861	39	861		5,525
16	Carpentry			2006	75,965	1948	39	1948		12,500
17	Doors Frames, Hardware			2006	44,426	1139	39	1139		7,309
18	Drywall			2006	90,127	2311	39	2311		14,829
19	Architectural Design			2006	54,849	1406	39	1406		9,022
20	Insulation			2006	1,090	28	39	28		180
21	Roofing			2006	13,298	341	39	341		2,188
22	Glass & Glazing			2006	14,790	379	39	379		2,432
23	Flooring			2006	35,828	919	39	919		5,897
24	Painting			2006	9,304	239	39	239		1,533
25	Fire Protection			2006	23,275	597	39	597		3,831
26	Plumbing			2006	255,033	6540	39	6540		41,963
27	HVAC			2006	64,445	1652	39	1652		10,600
28	Electric			2006	109,090	2797	39	2797		17,947
29	Communications Systems			2006	25,000	641	39	641		4,113
30	Extinguishers, railings, lighting			2006	45,374	1163	39	1163		7,463
31	water hookup			2006	6,000	154	39	154		988
32	site work			2006	15,200	390	39	390		2,502
33	wall lamps			2006	10,957	281	39	281		1,803
34	Painting			2007	1,192	31	39	31		186
35	Glass			2007	2,196	56	39	56		336
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building 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	Insurance	2007	\$ 4,834	\$ 124	39	\$ 124	\$	\$ 713	37
38	Overhead & Fees	2007	79,626	2,042	39	2,042		11,741	38
39	General Requirements	2007	57,076	1,463	39	1,463		8,413	39
40	Demolition	2007	33,088	848	39	848		4,876	40
41	Site work / foundation	2007	33,459	858	39	858		4,933	41
42	Concrete	2007	31,185	800	39	800		4,600	42
43	Masonry	2007	28,416	729	39	729		4,191	43
44	Carpentry	2007	120,204	3,082	39	3,082		17,610	44
45	Joints & Sealers	2007	1,413	36	39	36		207	45
46	Doors, Frames & Hardware	2007	86,147	2,209	39	2,209		12,702	46
47	Drywall	2007	121,143	3,107	39	3,107		17,753	47
48	Special Finishing	2007	50,225	1,288	39	1,288		7,406	48
49	Insulation	2007	1,414	36	39	36		207	49
50	Architectural	2007	14,424	370	39	370		2,127	50
51	Paving	2007	750	19	39	19		109	51
52	Roofing	2007	11,367	291	39	291		1,674	52
53	Glass & Glazing	2007	22,608	580	39	580		3,335	53
54	Flooring	2007	55,767	1,430	39	1,430		8,222	54
55	Wall Coverings	2007	17,900	459	39	459		2,639	55
56	Fire Protection	2007	25,200	646	39	646		3,715	56
57	Plumbing	2007	233,029	5,976	39	5,976		34,245	57
58	HVAC	2007	106,700	2,736	39	2,736		15,732	58
59	Electrical	2007	172,039	4,412	39	4,412		25,364	59
60	Communication Systems	2007	24,857	637	39	637		3,663	60
61	Landscaping	2007	2,920	75	39	75		431	61
62	Signage	2007	5,875	839	7	839		4,825	62
63	Floor Tile	2007	4,774	123	39	123		685	63
64	Building Pipe	2007	2,463	63	39	63		352	64
65	Building Permit	2007	2,935	75	39	75		420	65
66	2 Doors	2007	1,575	40	39	40		221	66
67	Floor Tile	2007	4,336	111	39	111		610	67
68	Flooring	2007	5,495	141	39	141		764	68
69	Construction Interest	2007	254,781	6,534	39	6,534		34,299	69
70	TOTAL (lines 4 thru 69)		\$ 3,615,307	\$ 93,391		\$ 93,391	\$	\$ 592,619	70

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,615,307	\$ 93,391		\$ 93,391	\$	\$ 592,619	1
2	Walk-in freezer	2007	10,281	1,469	7	1,469		7,590	2
3	Doors, & Fire Alarm	2007	7,577	194	39	194		986	3
4	Floor Tile	2008	2,358	60	39	60		300	4
5	Sprinklers	2008	11,969	307	39	307		1,459	5
6	Floor Tile	2008	8,368	214	39	214		1,000	6
7	Laminate Flooring	2008	7,562	194	39	194		889	7
8	Tile flooring - foyer	2009	4,261	109	39	109		382	8
9	Parking lot expansion	2009	26,860	689	39	689		2,182	9
10	Dining room floor	2009	9,167	235	39	235		724	10
11	Ductwork and registers for dining room	2009	6,500	166	39	166		512	11
12	Ceiling demo, new drywall and trimwork	2009	8,817	226	39	226		697	12
13	Electrical, lighting, trimwork, and installation	2009	25,639	657	39	657		2,026	13
14	Ceiling tiles	2009	11,256	289	39	289		891	14
15	Parking lot	2010	21,640	555	39	555		1,618	15
16	Water softener	2010	7,876	202	39	202		572	16
17	Dining room, office, recept walls, trimwork	2010	36,998	948	39	948		2,607	17
18	Dining room, office, reception trim, ceiling, floor	2010	49,716	1,275	39	1,275		3,507	18
19	Reception desk, counters	2010	5,759	147	39	147		368	19
20	Reception, office carpeting	2010	11,377	292	39	292		730	20
21									21
22	Electrical raceway, control	2011	8,146	209	39	209		401	22
23	Electrical, lighting	2011	3,820	98	39	98		163	23
24	Front office trimwork	2011	1,750	45	39	45		76	24
25	Parking lot	2011	18,000	461	39	461		693	25
26	Flooring for patient rooms	2011	5,649	145	39	145		206	26
27									27
28	Front office trimwork	2012	2,127	55	39	55		55	28
29	Therapy Counter	2012	1,015	24	39	24		24	29
30	Therapy Flooring	2012	2,927	56	39	56		56	30
31	Railing & Fence for Stairs	2012	2,403	15	39	15		15	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 3,935,125	\$ 102,727		\$ 102,727	\$	\$ 623,348	34

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

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	\$993,700	\$85,367	\$85,367	\$		\$915,751	71
72	Current Year Purchases	7,581	130	130			130	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,001,281	\$85,497	\$85,497	\$		\$915,881	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				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	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)	\$4,986,406	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$188,224	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$188,224	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)	\$1,539,229	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

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

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

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.
9. Option to Buy: ☐ YES ☐ NO Terms: *

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

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ Description:
- ☐ YES☐ NO
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

10. Effective dates of current rental agreement:
Beginning
Ending

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

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

* 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.

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

☒ 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

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

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

		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)	\$			

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		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	10-a1, 39-3	4103	hrs	\$ 147,243	25,589	\$ 288,036	\$	29,692	\$ 435,279	1
2	Licensed Speech and Language Development Therapist	10-a1, 39-3	456	hrs	16,360	2,843	32,004		3,299	48,364	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10-a1, 39-3	4559	hrs	163,605	28,432	320,040		32,991	483,645	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39-3		# of prescrpts				579,297		579,297	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Outpatient Services</u>	39-3						41,259		41,259	12
13	Other (specify): <u>Lab Services</u>	39-3						41,536		41,536	13
14	TOTAL				\$ 327,208	56,864	\$ 640,080	\$ 662,092	65,982	\$ 1,629,380	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.

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (266,691)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 93,000)	1,313,854		3
4	Supply Inventory (priced at)	14,879		4
5	Short-Term Investments			5
6	Prepaid Insurance	47,298		6
7	Other Prepaid Expenses	44,016		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,153,356	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	3,935,125		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,001,281		16
17	Accumulated Depreciation (book methods)	(1,539,229)		17
18	Deferred Charges	17,958		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec Deposits	11,685		22
23	Other(specify): Goodwill	244,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,720,820	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,874,176	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,279,234	\$	26
27	Officer's Accounts Payable	8,751		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	47,477		29
30	Accrued Salaries Payable	101,656		30
31	Accrued Taxes Payable (excluding real estate taxes)	722,396		31
32	Accrued Real Estate Taxes(Sch.IX-B)	13,556		32
33	Accrued Interest Payable	110,999		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,284,069	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	3,535,632		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)	\$ 3,535,632	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,819,701	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (945,525)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,874,176	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (697,593)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (697,593)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(247,932)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (247,932)	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)	\$ (945,525)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
I. Revenue	Amount		
A. Inpatient Care			
1Gross Revenue -- All Levels of Care	\$ 5,667,375	1	
2Discounts and Allowances for all Levels	()	2	
3SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,667,375	3	
B. Ancillary Revenue			
4Day Care		4	
5Other Care for Outpatients		5	
6Therapy		6	
7Oxygen		7	
8SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue			
9Payments for Education		9	
10Other Government Grants		10	
11CNA Training Reimbursements		11	
12Gift and Coffee Shop		12	
13Barber and Beauty Care		13	
14Non-Patient Meals		14	
15Telephone, Television and Radio		15	
16Rental of Facility Space		16	
17Sale of Drugs		17	
18Sale of Supplies to Non-Patients		18	
19Laboratory		19	
20Radiology and X-Ray		20	
21Other Medical Services		21	
22Laundry		22	
23SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23	
D. Non-Operating Revenue			
24Contributions		24	
25Interest and Other Investment Income***		25	
26SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26	
E. Other Revenue (specify):****			
27Settlement Income (Insurance, Legal, Etc.)		27	
28		28	
28a		28a	
29SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,667,375	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31General Services	646,615	31	
32Health Care	2,025,448	32	
33General Administration	1,161,350	33	
B. Capital Expense			
34Ownership	750,076	34	
C. Ancillary Expense			
35Special Cost Centers	1,302,172	35	
36Provider Participation Fee	29,646	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,915,307	40	
41Income before Income Taxes (line 30 minus line 40)**	(247,932)	41	
42Income Taxes		42	
43NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (247,932)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44Medicaid - Net Inpatient Revenue	\$ 2,818	44	
45Private Pay - Net Inpatient Revenue	122,582	45	
46Medicare - Net Inpatient Revenue	3,682,703	46	
47Other-(specify) Private Insurance Revenue	1,859,170	47	
48Other-(specify) Miscellaneous	102	48	
49TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,667,375	49	

* This must agree with page 4, line 45, column 4.
** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
*** 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.

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

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,246	2,246	\$ 93,650	\$ 41.70	1
2	Assistant Director of Nursing					2
3	Registered Nurses	25,989	25,989	743,318	28.60	3
4	Licensed Practical Nurses	10,082	10,082	258,495	25.64	4
5	CNAs & Orderlies	27,373	27,373	296,702	10.84	5
6	CNA Trainees					6
7	Licensed Therapist	10,016	10,016	327,208	32.67	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,948	1,948	35,484	18.22	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,417	1,417	26,659	18.81	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,021	13,021	147,645	11.34	15
16	Dishwashers					16
17	Maintenance Workers	527	527	18,725	35.53	17
18	Housekeepers	12,896	12,896	133,543	10.36	18
19	Laundry					19
20	Administrator	4,160	4,160	154,287	37.09	20
21	Assistant Administrator	2,080	2,080	74,345	35.74	21
22	Other Administrative					22
23	Office Manager	1,341	1,341	17,843	13.31	23
24	Clerical	2,289	2,289	96,248	42.05	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	3,504	3,504	87,094	24.86	33
34	TOTAL (lines 1 - 33)	118,889	118,889	\$ 2,511,246 *	\$ 21.12	34

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	550	\$ 18,523	1-3	35
36	Medical Director	325	28,709	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	875	\$ 47,232		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

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

** See instructions.

STATE OF ILLINOIS

0047209

Report Period Beginning:

01/01/12

Page 21

Ending: 12/31/12

Facility Name & ID Number

East Bank Center, LLC

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Renee Woods	Administrator	0	\$ 79,287	Workers' Compensation Insurance	\$ 63,000	IDPH License Fee	\$ 3,980	
Edna Atanacio	Asst Admin	0	74,345	Unemployment Compensation Insurance	29,927	Advertising: Employee Recruitment		
James Palazzo	Asst Admin	45.3	75,000	FICA Taxes	269,345	Health Care Worker Background Check		
				Employee Health Insurance	19,725	(Indicate # of checks performed 101)		
				Employee Meals		Patient Background Checks	457 6,420	
				Illinois Municipal Retirement Fund (IMRF)*		Fingerprinting	275	
				Retirement Plan Contributions	6,673	Marketing / Promotion / Public Relations	100,395	
				Disability Insurance	7,262			
				Life Insurance	9,295			
				Other	3,404			
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V,		TOTAL (agree to Sch. V,		
(List each licensed administrator separately.)			\$ 228,632	line 22, col.8)		line 20, col. 8)		
B. Administrative - Other								
Description			Amount					
			\$					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				to Owners or Employees				
C. Professional Services								
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	
Hovde & Tufo	Legal		\$ 13,962				Out-of-State Travel	
Wipfli CPA's	Accounting		17,742					
R. Peelo & Assoc.	Cost Reporting		3,750					
S. Haugh	Billing		5,850				In-State Travel	
Rockford Mercantile Exch	Collections		920				Gasoline	
Other / Accruals	Misc / Other		(680)					
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			Entertainment Expense	
(If total legal fees exceed \$5,000, attach copy of invoices.)			\$ 41,544				(agree to Sch. V,	
							line 24, col. 8)	
							\$ 3,699	

* Attach copy of IMRF notifications

**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?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

Yes

If YES, give association name and amount.

Illinois Health Care Assoc \$723
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?
- (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?

7 Years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

5,683

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.

\$

29,646

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.

\$

0

Has any meal income been offset against related costs?

No

Indicate the amount.

\$

0
- (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?

0%

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

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.

\$

N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:
- (18)

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

N/A
- (19)

If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report?

Yes

Attach invoices and a summary of services for all architect and appraisal fees.