

		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: 6/15/2005

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 01/01/2020 to 12/31/2020
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) James M. Palazzo
(Title) Manager

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 East Bank Center LLC

0047209 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>4</u>	<u>2,924</u>	<u>7,973</u>	<u>10,901</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>4</u>	<u>2,924</u>	<u>7,973</u>	<u>10,901</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 55.16%

D. How many bed reserve days during this year were paid by the Department? 0 (Do not include bed reserve 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 ☒

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 06/15/2005 NO ☐

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 7,973

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☐ NO ☐

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	180,509	5,354	28,607	214,470		214,470		214,470			1
2	Food Purchase		150,510		150,510		150,510		150,510			2
3	Housekeeping	216,159	15,542	23,189	254,890		254,890		254,890			3
4	Laundry		7,277		7,277		7,277		7,277			4
5	Heat and Other Utilities			82,612	82,612		82,612		82,612			5
6	Maintenance	1,750		58,006	59,756		59,756		59,756			6
7	Other (specify):*											7
8	TOTAL General Services	398,418	178,683	192,414	769,515		769,515		769,515			8
	B. Health Care and Programs											
9	Medical Director			13,500	13,500		13,500		13,500			9
10	Nursing and Medical Records	1,438,460	117,656	22,144	1,578,260		1,578,260		1,578,260			10
10a	Therapy											10a
11	Activities	74,883	900	350	76,133		76,133		76,133			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,513,343	118,556	35,994	1,667,893		1,667,893		1,667,893			16
	C. General Administration											
17	Administrative	369,171			369,171		369,171		369,171			17
18	Directors Fees											18
19	Professional Services			37,058	37,058		37,058		37,058			19
20	Dues, Fees, Subscriptions & Promotions			21,227	21,227		21,227		21,227			20
21	Clerical & General Office Expenses		22,421	187,479	209,900		209,900		209,900			21
22	Employee Benefits & Payroll Taxes			320,065	320,065		320,065		320,065			22
23	Inservice Training & Education											23
24	Travel and Seminar			18,947	18,947		18,947		18,947			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			188,125	188,125		188,125		188,125			26
27	Other (specify):* Promo / bad debt			162,958	162,958		162,958		162,958			27
28	TOTAL General Administration	369,171	22,421	935,859	1,327,451		1,327,451		1,327,451			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,280,932	319,660	1,164,267	3,764,859		3,764,859		3,764,859			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			119,473	119,473		119,473		119,473			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			378,211	378,211		378,211		378,211			32
33	Real Estate Taxes			29,097	29,097		29,097		29,097			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* debt forg / stimulus			(2,031,276)	(2,031,276)		(2,031,276)		(2,031,276)			36
37	TOTAL Ownership			(1,504,495)	(1,504,495)		(1,504,495)		(1,504,495)			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,561,805	1,561,805		1,561,805		1,561,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,515	36,515		36,515		36,515			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,598,320	1,598,320		1,598,320		1,598,320			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,280,932	319,660	1,258,092	3,858,684		3,858,684		3,858,684			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.)

	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	(7,982)			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	(155,009)			24
25	Fund Raising, Advertising and Promotional	(7,950)			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				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (170,941)		\$	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			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (170,941)		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	Outpatient Services	X		13,653	39-3	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology	X		89,573	39-3	42
43	Prescription Drugs	X		445,358	39-3	43
44	Illinois bed tax / assessment	X		36,515	42-3	44
45	Other-Attach Schedule Therapy Ser	X		1,013,221	39-3	45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 1,598,320		47

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
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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: 01/01/2020 Ending: 12/31/2020

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	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0	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):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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)	0	0	0	0	0	0	0	0	0	0	0	0	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
Advanced Management Company	98.51			Transitions Hospice		Hospice
E. Atanacio	1.49			Advantage Medical Equipment		DME and Supplies
				Axis Management		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	10	DME Supplies	\$ 22,379	Advantage Medical Equipment		\$ 22,379		1
2	V								2
3	V								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			\$ 22,379			\$ 22,379	\$ *	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

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

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	Activities/Admiss/Dis	Activities/Admin	0.01	0	40	100.00	wages	\$ 74,883	11-1	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	\$ 74,883		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 East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

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 ☐ NO ☐

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

Name of Related Organization _____
Street Address _____
City / State / Zip Code _____
Phone Number () _____
Fax Number () _____

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
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	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	BZ Grandchildren Trust		X	Mortgage	\$31,500.00	2/1/20	\$ 2,400,000	\$		10.0000	\$ 346,500	1	
2	Advanced Management Co.	X		Operations	None		159,463					2	
3	S. Parekh	X		Operations	None		70,000				11,250	3	
4	J. Palazzo	X		Operations	None		8,751					4	
5	U. Parekh	X		Term Loan	Interest	1/31/14	250,000			2.5000	6,250	5	
	Working Capital												
6	U. Parekh	X		Working Capital / LOC	None	11/5/14	471,000			2.5000	8,723	6	
7	Miscellaneous		X	Working Capital / vendor	None	N/A					5,488	7	
8												8	
9	TOTAL Facility Related				\$31,500.00		\$ 3,359,214	\$			\$ 378,211	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,359,214	\$			\$ 378,211	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 2019 report.			\$	33,523	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.)			\$	30,546	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(2,977)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	32,074	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.			\$	29,097	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2015	31,133	8	
		2016	30,773	9	
		2017	31,091	10	
		2018	31,927	11	
		2019	30,546	12	
		FOR BHF USE ONLY			
		13	FROM R. E. TAX STATEMENT FOR 2019 \$		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.

2019 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 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 11-01-252-012	Facility & Land	\$ 29,608.00	\$
2. 11-01-177-016	Land	\$ 938.00	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 30,546.00	\$

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

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		\$ 21,652	\$	\$ 337,411
5										
6										
7										
8										
	Improvement Type**									
9	Building Wings A, B, C, & Front									
10	Insurance			2006	7,780	199	39	199		2,871
11	Overhead& Fee			2006	79,134	2029	39	2029		29,251
12	General Requirements			2006	86,308	2213	39	2213		31,904
13	Demolition			2006	33,784	866	39	866		12,485
14	Concrete			2006	14,818	380	39	380		5,478
15	Masonry			2006	33,589	861	39	861		12,413
16	Carpentry			2006	75,965	1948	39	1948		28,084
17	Doors Frames, Hardware			2006	44,426	1139	39	1139		16,421
18	Drywall			2006	90,127	2311	39	2311		33,317
19	Architectural Design			2006	54,849	1406	39	1406		20,270
20	Insulation			2006	1,090	28	39	28		404
21	Roofing			2006	13,298	341	39	341		4,916
22	Glass & Glazing			2006	14,790	379	39	379		5,464
23	Flooring			2006	35,828	919	39	919		13,249
24	Painting			2006	9,304	239	39	239		3,445
25	Fire Protection			2006	23,275	597	39	597		8,607
26	Plumbing			2006	255,033	6541	39	6541		94,291
27	HVAC			2006	64,445	1652	39	1652		23,816
28	Electric			2006	109,090	2797	39	2797		40,324
29	Communications Systems			2006	25,000	641	39	641		9,241
30	Extinguishers, railings, lighting			2006	45,374	1163	39	1163		16,767
31	water hookup			2006	6,000	154	39	154		2,220
32	site work			2006	15,200	390	39	390		5,622
33	wall lamps			2006	10,957	281	39	281		4,051
34	Painting			2007	1,192	31	39	31		434
35	Glass			2007	2,196	56	39	56		783
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 East Bank Center LLC

0047209

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Insurance	2007	\$ 4,834	\$ 124	39	\$ 124	\$	\$ 1,705	37
38	Overhead & Fees	2007	79,626	2,042	39	2,042		28,076	38
39	General Requirements	2007	57,076	1,463	39	1,463		20,117	39
40	Demolition	2007	33,088	848	39	848		11,660	40
41	Site work / foundation	2007	33,459	858	39	858		11,797	41
42	Concrete	2007	31,185	800	39	800		11,000	42
43	Masonry	2007	28,416	729	39	729		10,023	43
44	Carpentry	2007	120,204	3,081	39	3,081		42,258	44
45	Joints & Sealers	2007	1,413	36	39	36		495	45
46	Doors, Frames & Hardware	2007	86,147	2,209	39	2,209		30,374	46
47	Drywall	2007	121,143	3,107	39	3,107		42,608	47
48	Special Finishing	2007	50,225	1,288	39	1,288		17,710	48
49	Insulation	2007	1,414	36	39	36		495	49
50	Architectural	2007	14,424	370	39	370		5,087	50
51	Paving	2007	750	19	39	19		261	51
52	Roofing	2007	11,367	291	39	291		4,002	52
53	Glass & Glazing	2007	22,608	580	39	580		7,975	53
54	Flooring	2007	55,767	1,430	39	1,430		19,662	54
55	Wall Coverings	2007	17,900	459	39	459		6,311	55
56	Fire Protection	2007	25,200	646	39	646		8,883	56
57	Plumbing	2007	233,029	5,975	39	5,975		82,045	57
58	HVAC	2007	106,700	2,736	39	2,736		37,620	58
59	Electrical	2007	172,039	4,412	39	4,412		60,659	59
60	Communication Systems	2007	24,857	637	39	637		8,759	60
61	Landscaping	2007	2,920	75	39	75		1,031	61
62	Signage	2007	5,875		7			5,875	62
63	Floor Tile	2007	4,774	123	39	123		1,668	63
64	Building Pipe	2007	2,463	63	39	63		856	64
65	Building Permit	2007	2,935	75	39	75		1,020	65
66	2 Doors	2007	1,575	40	39	40		544	66
67	Floor Tile	2007	4,336	111	39	111		1,499	67
68	Flooring	2007	5,495	141	39	141		1,891	68
69	Construction Interest	2007	254,781	6,533	39	6,533		86,561	69
70	TOTAL (lines 4 thru 69)		\$ 3,615,307	\$ 92,550		\$ 92,550	\$	\$ 1,334,066	70

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

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning:

01/01/2020 Ending: 12/31/2020

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	
	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	\$ 92,550		\$ 92,550	\$	\$ 1,334,066	1
2	Walk-in freezer	2007	10,281		7			10,281	2
3	Doors, & Fire Alarm	2007	7,577	194	39	194		2,540	3
4	Floor Tile	2008	2,358	60	39	60		784	4
5	Sprinklers	2008	11,969	307	39	307		3,914	5
6	Floor Tile	2008	8,368	215	39	215		2,720	6
7	Laminate Flooring	2008	7,562	193	39	193		2,435	7
8	Tile flooring - foyer	2009	4,261	109	39	109		1,255	8
9	Parking lot expansion	2009	26,860	689	39	689		7,692	9
10	Dining room floor	2009	9,167	235	39	235		2,605	10
11	Ductwork and registers for dining room	2009	6,500	167	39	167		1,849	11
12	Ceiling demo, new drywall and trimwork	2009	8,817	226	39	226		2,505	12
13	Electrical, lighting, trimwork, and installation	2009	25,639	657	39	657		7,284	13
14	Ceiling tiles	2009	11,256	289	39	289		3,201	14
15	Parking lot	2010	21,640	555	39	555		6,058	15
16	Water softener	2010	7,876	202	39	202		2,188	16
17	Dining room, office, recept walls, trimwork	2010	36,998	948	39	948		10,194	17
18	Dining room, office, reception trim, ceiling, floor	2010	49,716	1,275	39	1,275		13,705	18
19	Reception desk, counters	2010	5,759	148	39	148		1,553	19
20	Reception, office carpeting	2010	11,377	292	39	292		3,065	20
21									21
22	Electrical raceway, control	2011	8,146	209	39	209		2,072	22
23	Electrical, lighting	2011	3,820	98	39	98		947	23
24	Front office trimwork	2011	1,750	45	39	45		434	24
25	Parking lot	2011	18,000	461	39	461		4,381	25
26	Flooring for patient rooms	2011	5,649	145	39	145		1,365	26
27									27
28	Front office trimwork	2012	2,127	55	39	55		493	28
29	Therapy Counter	2012	1,015	26	39	26		232	29
30	Therapy Flooring	2012	2,927	75	39	75		656	30
31	Railing & Fence for Stairs	2012	2,403	62	39	62		510	31
32	Water Heaters	2013	12,800	328	39	328		2,515	32
33	Electrical Panel/breaker/run	2013	14,653	376	39	376		2,882	33
34	TOTAL (lines 1 thru 33)		\$ 3,962,578	\$ 101,191		\$ 101,191	\$	\$ 1,436,381	34

**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	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 3,962,578	\$ 101,191		\$ 101,191	\$	\$ 1,436,381	1
2 Dr. Office Trimwork	2014	2,481	64	39	64		442	2
3 Capitalized Interest	2014	2,872	74	39	74		499	3
4 Trees	2014	2,000	51	39	51		336	4
5 Hallway Carpeting	2014	16,000	409	39	409		2,524	5
6 Boiler	2014	3,780	97	39	97		590	6
7								7
8 Boiler	2015	4,400	113	39	113		640	8
9 Boiler Pump	2015	1,151	30	39	30		162	9
10								10
11 Roofing	2016	13,975	358	39	358		1,641	11
12 Roofing	2016	3,361	86	39	86		394	12
13 Flooring - patient rooms wing A, nurse station, office	2017	5,477	140	39	140		491	13
14 Re-wiring for all A/C Units and main line	2017	25,685	658	39	658		2,084	14
15 Sliding Door North Wall	2018	12,974	333	39	333		860	15
16 Furnace / Heat Exchanger	2018	5,449	140	39	140		315	16
17 Kitchen sinks and plumbing	2019	5,317	23	39	23		159	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 TOTAL (lines 1 thru 33)		\$ 4,067,500	\$ 103,767		\$ 103,767	\$	\$ 1,447,518	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	\$1,101,554	\$15,593	\$15,593	\$		\$1,058,474	71
72	Current Year Purchases	15,778						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,117,332	\$15,593	\$15,593	\$		\$1,058,474	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				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference			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)			\$	5,234,832
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	119,360
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	119,360
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	2,505,992

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		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
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? ☐ YES ☐ NO
16. Rental Amount for movable equipment: \$ _____ Description: _____
(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.

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

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)	\$			

- (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.

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	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)											
		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service			Units	Cost				
1	Licensed Occupational Therapist	10a-1	9370	hrs	\$ 455,950		\$	\$	9,370	\$ 455,950	1
2	Licensed Speech and Language Development Therapist	10a-1	1041	hrs	50,662				1,041	50,662	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a-1	10411	hrs	506,609				10,411	506,609	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				445,358		445,358	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)										
10				hrs							10
11	Academic Education			hrs							11
12	Other (specify): <u>Outpatient Services</u>	39-3						13,653		13,653	12
13	Other (specify): <u>Lab Services</u>	39-3						89,573		89,573	13
14	TOTAL				\$ 1,013,221		\$	\$ 548,584	20,822	\$ 1,561,805	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 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 859,150	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 175,247)	625,928		3
4	Supply Inventory (priced at)	16,193		4
5	Short-Term Investments			5
6	Prepaid Insurance	28,748		6
7	Other Prepaid Expenses	27,404		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,557,423	\$	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	4,067,499		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,117,333		16
17	Accumulated Depreciation (book methods)	(2,505,992)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Deposits	9,310		22
23	Other(specify): Goodwill	244,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,982,150	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,539,573	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 525,517	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,990		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,310		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,074		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	107,561		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 898,452	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,579,091		39
40	Mortgage Payable	2,400,000		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)	\$ 3,979,091	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,877,543	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ (337,970)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,539,573	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (3,384,947)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (3,384,947)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,858,375	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) Related Party write off	1,188,602	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 3,046,977	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)	\$ (337,970)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

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

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,717,059	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,717,059	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,717,059	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	769,515	31
32	Health Care	1,667,893	32
33	General Administration	1,327,451	33
	B. Capital Expense		
34	Ownership	(1,504,495)	34
	C. Ancillary Expense		
35	Special Cost Centers	1,598,320	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,858,684	40
41	Income before Income Taxes (line 30 minus line 40)**	1,858,375	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 1,858,375	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$	44
45	Private Pay - Net Inpatient Revenue	162,073	45
46	Medicare - Net Inpatient Revenue	4,393,919	46
47	Other-(specify) <u>Commercial Insurance Revenue</u>	1,159,762	47
48	Other-(specify) <u>Miscellaneous Revenue</u>	1,305	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,717,059	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	2,080	2,080	\$ 116,513	\$ 56.02	1
2	Assistant Director of Nursing					2
3	Registered Nurses	18,380	18,380	608,122	33.09	3
4	Licensed Practical Nurses	8,996	8,996	273,856	30.44	4
5	CNAs & Orderlies	31,174	31,174	439,969	14.11	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,343	2,343	74,883	31.96	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	14,936	14,936	180,509	12.09	15
16	Dishwashers					16
17	Maintenance Workers	80	80	1,750	21.88	17
18	Housekeepers	16,015	16,015	216,159	13.50	18
19	Laundry					19
20	Administrator	2,526	2,526	123,891	49.05	20
21	Assistant Administrator					21
22	Other Administrative	7,941	7,941	134,318	16.91	22
23	Office Manager					23
24	Clerical	4,530	4,530	110,962	24.49	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)					33
34	TOTAL (lines 1 - 33)	109,001	109,001	\$ 2,280,932 *	\$ 20.93	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	300	\$ 20,760	1-3	35
36	Medical Director	72	13,500	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	35	1,776	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	407	\$ 36,036		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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Patrick Scales	Administrator	0	\$ 65,000
Nicole Garner	Administrator	0	58,891
Various	Admin	0	134,318
Various	Clerical	0	110,962
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 369,171
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
			\$
Hovde & Tufo	Legal		13,000
Wipfli CPA's	Accounting		15,340
R. Peelo & Associates	Cost Reporting		3,750
Joint Commission	Accreditation		2,850
Other	Other		2,118
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 37,058
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 33,574
Unemployment Compensation Insurance			19,433
FICA Taxes			174,899
Employee Health Insurance			41,621
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Retirement plan contributions			32,108
Disability insurance			4,221
Miscellaneous			14,209
TOTAL (agree to Schedule V, line 22, col.8)			\$ 320,065
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 3,980
Advertising: Employee Recruitment			5,686
Health Care Worker Background Check (Indicate # of checks performed 48)			1,680
Patient Background Checks 463			4,931
Fingerprinting			4,590
Marketing/Promotion/Public Relations			7,950
Licenses / Permits			6,930
Less: Public Relations Expense (			)
Non-allowable advertising			(7,950)
Yellow page advertising (			)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 27,797
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			17,793
Seminar Expense			1,154
Entertainment Expense (			)
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 18,947

*** Attach copy of IMRF notifications**

****See instructions.**

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?
If YES, give association name and amount. No
- (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? N/A
- (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?
What was the average life used for new equipment added during this period? Yes
7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 10,863 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. N/A
- (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.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,515
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. \$ N/A
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: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (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. Yes
Attach invoices and a summary of services for all architect and appraisal fees.