

		FOR BHF USE					

LL1

2025

STATE OF ILLINOIS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

FINANCIAL AND STATISTICAL REPORT (COST REPORT)

FOR LONG-TERM CARE FACILITIES

(FISCAL YEAR 2025)

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

NumberCityZip 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 DaleTelephone Number: (815) 633-6810

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 01/01/2025 to 12/31/2025 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) James M. Palazzo

(Title) Manager

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
2200 Churchill Rd.
Springfield, IL 62702-3406 Phone # (217) 782-1630

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	54	Skilled (SNF)	54	19,710	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	54	TOTALS	54	19,710	7

B. Census-For the entire report period.

	1	2	3	4	5	6	7	8	9	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment								
		Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total	
				Medicaid Primary	Medicare Primary					
8	SNF	440			316	798	6,118	2,939	10,611	8
9	SNF/PED									9
10	ICF									10
11	ICF/DD									11
12	SC									12
13	DD 16 OR LESS									13
14	TOTALS	440			316	798	6,118	2,939	10,611	14

C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.) 53.84%

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 6/15/2005

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 6/15/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter certified beds. number of certified beds 54

Medicare Intermediary NGS

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

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

Tax Year: 12/31/2025 Fiscal Year: 12/31/2025

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

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2025 Ending: 12/31/2025

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	257,996	674	75,316	333,986		333,986		333,986			1
2	Food Purchase		204,065		204,065		204,065		204,065			2
3	Housekeeping	188,205	10,815	4,714	203,734		203,734		203,734			3
4	Laundry											4
5	Heat and Other Utilities			118,370	118,370		118,370	11,525	129,895			5
6	Maintenance	68,122		29,136	97,258		97,258		97,258			6
7	Other (specify):*											7
8	TOTAL General Services	514,323	215,554	227,536	957,413		957,413	11,525	968,938			8
	B. Health Care and Programs											
9	Medical Director			13,988	13,988		13,988		13,988			9
10	Nursing and Medical Records	2,004,566	95,617		2,100,183		2,100,183		2,100,183			10
10a	Therapy	505,838			505,838		505,838		505,838			10a
11	Activities	79,510	850	3,035	83,395		83,395		83,395			11
12	Social Services											12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,589,914	96,467	17,023	2,703,404		2,703,404		2,703,404			16
	C. General Administration											
17	Administrative											17
18	Directors Fees											18
19	Professional Services			36,210	36,210		36,210		36,210			19
20	Dues, Fees, Subscriptions & Promotions			14,412	14,412		14,412		14,412			20
21	Clerical & General Office Expenses	176,411	1,950	433,238	611,599		611,599		611,599			21
22	Employee Benefits & Payroll Taxes			626,353	626,353		626,353		626,353			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,213	7,213		7,213		7,213			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			279,500	279,500		279,500		279,500			26
27	Other (specify):*	50,473		80,347	130,820		130,820	130,820	261,640			27
28	TOTAL General Administration	226,884	1,950	1,477,273	1,706,107		1,706,107	130,820	1,836,927			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,331,121	313,971	1,721,832	5,366,924		5,366,924	142,345	5,509,269			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			22,979	22,979		22,979		22,979			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,157	7,157		7,157		7,157			32
33	Real Estate Taxes			39,000	39,000		39,000		39,000			33
34	Rent-Facility & Grounds			378,000	378,000		378,000		378,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* non-recurring			72,860	72,860		72,860		72,860			36
37	TOTAL Ownership			519,996	519,996		519,996		519,996			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			352,129	352,129		352,129		352,129			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			48,000	48,000		48,000		48,000			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			400,129	400,129		400,129		400,129			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,331,121	313,971	2,641,957	6,287,049		6,287,049	142,345	6,429,394			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	11,525	5-3		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	74,200	27-3		24
25	Fund Raising, Advertising and Promotional	56,620	27-3		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)	\$ 142,345		\$	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))	\$ 142,345		37

*These costs are only allowable if they are necessary to meet minimum
licensing standards. Attach a schedule detailing the items included
on these lines.

C. Are the following expenses included in Sections A to D of pages 3
and 4? If so, they should be reclassified into Section E. Please
reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Political Action Committee Payments	\$ 0	20	1
2	Other Expenses Related to Lobbying Activities			2
3	Telephone TV Radio in Patient Rooms	11,525	5	3
4	Bad debt	74,200	27	4
5	Fund raising, promotional	56,620	27	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
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41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	142,345		49

Summary A

12/31/2025

[illegible]

Summary B

12/31/2025

[illegible]

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	100.00			Transitions Hospice	Elk Grove, IL	Hospice
				Advantage Medical Eq	Elk Grove, IL	DME and Supplies
				Advanced Managemen	Loves Park, IL	Admin Services

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	\$	Advantage Medical Equipment		\$	\$	1
2	V	34	Facility Rent	378,000	EBC Loves Park LLC		378,000		2
3	V	21	Admin Services	282,427	Advanced Management Company LLC		282,427		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			\$ 660,427			\$ 660,427	\$ *	14

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

VII. RELATED PARTIES (continued)

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

☐ YES

☐ NO

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

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

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

Ownership Listing-1

ID# 0047209

-Names of trust beneficiaries must be listed.

James	M	Palazzo	St Charles	IL	99.00000	99.00000	99.00000	1
James	B	Dale	Maitland	FL	1.00000	1.00000	1.00000	2
3								3
4								4
5								5
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75								75

Ownership Listing-2

ID# 0047209

01/01/2025

12/31/2025

Co. / Home Office

Percentage

76								76
77								77
78								78
79								79
80								80
81								81
82								82
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150								150

VII. RELATED PARTIES

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

	1 RELATED NURSING HOMES		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Facility Name	City, State	Facility Name	City, State	Name	City, State	Type of Business	
1								1
2								2
3								3
4								4
5								5
6								6
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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	Advanced Management Comp	Manager	Admin Services	100.00	None	N/A	N/A	Mgmt Fee	\$ 282,427	21-3	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	\$ 282,427		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: 01/01/2025 Ending: 2/31/2025

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 Advanced Management Company LLC
Street Address 6131 Park Ridge Rd
City / State / Zip Code Loves Park, IL 61111
Phone Number (815) 633-6810
Fax Number (815) 633-6810

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6		
	1	21-3	Management Fees	Direct Cost	1	0	\$ 282,427	\$ 0	1	\$ 282,427	1
	2										2
	3										3
	4										4
	5										5
	6										6
	7										7
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	19										19
	20										20
	21										21
	22										22
	23										23
	24										24
	25	TOTALS				\$ 282,427	\$		\$ 282,427		25

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2025 Ending: 2/31/2025

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							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	SBA EIDL		X	working capital	\$781.00	3/31/2020	150,000		3/31/2027	4.0000	2,478	6	
7	various		X								4,679	7	
8												8	
9	TOTAL Facility Related				\$781.00		\$ 150,000	\$			\$ 7,157	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 150,000	\$			\$ 7,157	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 2024 report.			\$	37,116	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.)			\$	37,362	2
3. Under or (over) accrual (line 2 minus line 1).			\$	246	3
4. Real Estate Tax accrual used for 2025 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	38,754	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.			\$	39,000	7
Assessed Value from Real Estate Tax Bill:	2024		8		
Real Estate Tax Bill for Calendar Year:	2020	29,763	9		
	2021	32,345	10		
	2022	34,384	11		
	2023	35,348	12		
	2024	37,362	13		
				FOR BHF USE ONLY	
				14	FROM R. E. TAX STATEMENT FOR 2024 \$ 14
				15	PLUS APPEAL COST FROM LINE 5 \$ 15
				16	LESS REFUND FROM LINE 6 \$ 16
				17	AMOUNT TO USE FOR RATE CALCULATION \$ 17

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.

2024 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) 633-6810 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2024 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 2024.

	(A)	(B)	(C)	(D)
				<u>Tax</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
				<u>Nursing Home</u>
1.	11-01-252-012	Facility & Land	\$ 35,844.00	\$ 35,844.00
2.	11-01-177-016	Land	\$ 1,518.00	\$ 1,518.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 37,362.00	\$ 37,362.00

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 2024 tax bills which were listed in Section A to this statement. Be sure to use the 2024 tax bill which is normally paid during 2025.

PLEASE NOTE: Payment information from the Internet or otherwise is not considered acceptable tax bill documentation . Facilities located in Cook County are required to providecopies 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 (X) (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (X) (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

F. List the bed capacity for the building if it differs from the licensed total.
G. Have you properly capitalized all major repairs and equipment purchases? Yes
H. Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease.
I. Are you presently operating under a sublease agreement? No
J. 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.

K. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES X NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning:

01/01/2025

Ending:

12/31/2025

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	\$ 9,099	39	\$ 9,099		\$
5										
6										
7										
8										
	Improvement Type**									
9	Building Wings A, B, C, & Front									
10	Insurance			2006	7,780	84	39	84		
11	Overhead& Fee			2006	79,134	853	39	853		
12	General Requirements			2006	86,308	930	39	930		
13	Demolition			2006	33,784	364	39	364		
14	Concrete			2006	14,818	160	39	160		
15	Masonry			2006	33,589	362	39	362		
16	Carpentry			2006	75,965	818	39	818		
17	Doors Frames, Hardware			2006	44,426	479	39	479		
18	Drywall			2006	90,127	971	39	971		
19	Architectural Design			2006	54,849	591	39	591		
20	Insulation			2006	1,090	12	39	12		
21	Roofing			2006	13,298	143	39	143		
22	Glass & Glazing			2006	14,790	159	39	159		
23	Flooring			2006	35,828	386	39	386		
24	Painting			2006	9,304	100	39	100		
25	Fire Protection			2006	23,275	251	39	251		
26	Plumbing			2006	255,033	2,748	39	2,748		
27	HVAC			2006	64,445	694	39	694		
28	Electric			2006	109,090	1,175	39	1,175		
29	Communications Systems			2006	25,000	269	39	269		
30	Extinguishers, railings, lighting			2006	45,374	489	39	489		
31	water hookup			2006	6,000	65	39	65		
32	site work			2006	15,200	164	39	164		
33	wall lamps			2006	10,957	118	39	118		
34	Painting			2007	1,192	13	39	13		
35	Glass			2007	2,196	23	39	23		
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:

01/01/2025 Ending: 12/31/2025

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	\$ 52	39	\$ 52	\$	\$	37
38	Overhead & Fees	2007	79,626	850	39	850			38
39	General Requirements	2007	57,076	609	39	609			39
40	Demolition	2007	33,088	353	39	353			40
41	Site work / foundation	2007	33,459	357	39	357			41
42	Concrete	2007	31,185	333	39	333			42
43	Masonry	2007	28,416	303	39	303			43
44	Carpentry	2007	120,204	1,282	39	1,282			44
45	Joints & Sealers	2007	1,413	15	39	15			45
46	Doors, Frames & Hardware	2007	86,147	919	39	919			46
47	Drywall	2007	121,143	1,292	39	1,292			47
48	Special Finishing	2007	50,225	536	39	536			48
49	Insulation	2007	1,414	15	39	15			49
50	Architectural	2007	14,424	154	39	154			50
51	Paving	2007	750	8	39	8			51
52	Roofing	2007	11,367	121	39	121			52
53	Glass & Glazing	2007	22,608	241	39	241			53
54	Flooring	2007	55,767	595	39	595			54
55	Wall Coverings	2007	17,900	191	39	191			55
56	Fire Protection	2007	25,200	269	39	269			56
57	Plumbing	2007	233,029	2,486	39	2,486			57
58	HVAC	2007	106,700	1,138	39	1,138			58
59	Electrical	2007	172,039	1,835	39	1,835			59
60	Communication Systems	2007	24,857	265	39	265			60
61	Landscaping	2007	2,920	31	39	31			61
62	Signage	2007	5,875	63	7	63			62
63	Floor Tile	2007	4,774	51	39	51			63
64	Building Pipe	2007	2,463	26	39	26			64
65	Building Permit	2007	2,935	31	39	31			65
66	2 Doors	2007	1,575	17	39	17			66
67	Floor Tile	2007	4,336	46	39	46			67
68	Flooring	2007	5,495	59	39	59			68
69	Construction Interest	2007	254,781	2,718	39	2,718			69
70	TOTAL (lines 4 thru 69)		\$ 3,615,307	\$ 38,781		\$ 38,781	\$	\$	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:

01/01/2025 Ending: 12/31/2025

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	\$ 38,781		\$ 38,781	\$	\$	1
2	Walk-in freezer	2007	10,281	110	7	110			2
3	Doors, & Fire Alarm	2007	7,577	81	39	81			3
4	Floor Tile	2008	2,358	25	39	25			4
5	Sprinklers	2008	11,969	129	39	129			5
6	Floor Tile	2008	8,368	90	39	90			6
7	Laminate Flooring	2008	7,562	81	39	81			7
8	Tile flooring - foyer	2009	4,261	46	39	46			8
9	Parking lot expansion	2009	26,860	289	39	289			9
10	Dining room floor	2009	9,167	99	39	99			10
11	Ductwork and registers for dining room	2009	6,500	70	39	70			11
12	Ceiling demo, new drywall and trimwork	2009	8,817	95	39	95			12
13	Electrical, lighting, trimwork, and installation	2009	25,639	276	39	276			13
14	Ceiling tiles	2009	11,256	121	39	121			14
15	Parking lot	2010	21,640	233	39	233			15
16	Water softener	2010	7,876	85	39	85			16
17	Dining room, office, recept walls, trimwork	2010	36,998	399	39	399			17
18	Dining room, office, reception trim, ceiling, floor	2010	49,716	537	39	537			18
19	Reception desk, counters	2010	5,759	62	39	62			19
20	Reception, office carpeting	2010	11,377	123	39	123			20
21									21
22	Electrical raceway, control	2011	8,146	88	39	88			22
23	Electrical, lighting	2011	3,820	41	39	41			23
24	Front office trimwork	2011	1,750	19	39	19			24
25	Parking lot	2011	18,000	194	39	194			25
26	Flooring for patient rooms	2011	5,649	61	39	61			26
27									27
28	Front office trimwork	2012	2,127	23	39	23			28
29	Therapy Counter	2012	1,015	11	39	11			29
30	Therapy Flooring	2012	2,927	32	39	32			30
31	Railing & Fence for Stairs	2012	2,403	26	39	26			31
32	Water Heaters	2013	12,800	138	39	138			32
33	Electrical Panel/breaker/run	2013	14,653	158	39	158			33
34	TOTAL (lines 1 thru 33)		\$ 3,962,578	\$ 42,523		\$ 42,523	\$	\$	34

**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:

01/01/2025 Ending: 12/31/2025

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 12B, Carried Forward		\$ 3,962,578	\$ 42,523		\$ 42,523	\$	\$	1
2	Dr. Office Trimwork	2014	2,481	27	39	27			2
3	Capitalized Interest	2014	2,872	31	39	31			3
4	Trees	2014	2,000	21	39	21			4
5	Hallway Carpeting	2014	16,000	173	39	173			5
6	Boiler	2014	3,780	41	39	41			6
7									7
8	Boiler	2015	4,400	47	39	47			8
9	Boiler Pump	2015	1,151	12	39	12			9
10									10
11	Roofing	2016	13,975	151	39	151			11
12	Roofing	2016	3,361	36	39	36			12
13	Flooring - patient rooms wing A, nurse station, office	2017	5,477	59	39	59			13
14	Re-wiring for all A/C Units and main line	2017	25,685	278	39	278			14
15	Sliding Door North Wall	2018	12,974	140	39	140			15
16	Furnace / Heat Exchanger	2018	5,449	59	39	59			16
17	Kitchen sinks and plumbing	2019	5,317	57	39	57			17
18									18
19	Plumbing System	2021	4,500	44	39	44			19
20	Plumbing System	2021	5,715	51	39	51			20
21									21
22	Roof Replacement	2022	31,500	808	39	808			22
23									23
24	HVAC	2023	11,386	73	39	73			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)		\$ 4,120,601	\$ 44,631		\$ 44,631	\$	\$	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	\$1,232,496	\$21,528	\$	\$(21,528)		\$1,172,346	71
72	Current Year Purchases	16,689	1,451		(1,451)		1,451	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,249,185	\$22,979	\$	\$(22,979)		\$1,173,797	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)	\$5,369,786	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$67,610	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$44,631	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(22,979)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$1,173,797	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: EBC Loves Park LLC
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:	1970	54	6/1/2021	\$378,000	4	1	3
4	Additions							4
5								5
6								6
7	TOTAL		54		\$378,000			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
- None
N/A

9. Option to Buy:
- ☐ YES☒ X 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	None		\$	\$	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.

10. Effective dates of current rental agreement:
- Beginning6/1/2021
- Ending6/1/2026

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

	Fiscal Year Ending	Annual Rent
12.	12/31/2026	\$157,500
13.	12/31/2027	\$0
14.	12/31/2028	\$0

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
		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.

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	

- (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	10a-1 / 39-3	8436	hrs	\$ 227,627		\$	8,436	\$ 227,627	1
2	Licensed Speech and Language Development Therapist	10a-1 / 39-3	937	hrs	25,292			937	25,292	2
3	Licensed Recreational Therapist			hrs						3
4	Licensed Physical Therapist	10a-1 / 39-3	9373	hrs	252,919			9,373	252,919	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			278,803		278,803	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs						10
11	Academic Education			hrs						11
12	Other (specify): Outpatient Services	39-3					5,667		5,667	12
13	Other (specify): Lab Services	39-3					67,659		67,659	13
14	TOTAL				\$ 505,838	\$	\$ 352,129	18,746	\$ 857,967	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.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 14,954	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 185,620)	872,163		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	101,584		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 988,701	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,249,185		16
17	Accumulated Depreciation (book methods)	(1,173,797)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) Deposits	9,310		22
23	Other(specify): Goodwill	244,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 328,698	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,317,399	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,374,071	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	172,865		30
31	Accrued Taxes Payable (excluding real estate taxes)	10,560		31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,455		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	503,755		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,115,706	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	735,565		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 735,565	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,851,271	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,533,872)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,317,399	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (996,871)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (996,871)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(537,001)	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)	\$ (537,001)	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)	\$ (1,533,872)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning: 01/01/2025

Ending: 12/31/2025

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	\$ 5,750,048	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,750,048	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)	\$ 5,750,048	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	957,413	31
32	Health Care	2,703,404	32
33	General Administration	1,706,107	33
	B. Capital Expense		
34	Ownership	519,996	34
	C. Ancillary Expense		
35	Special Cost Centers	352,129	35
36	Provider Participation Fee	48,000	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,287,049	40
41	Income before Income Taxes (line 30 minus line 40)**	(537,001)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (537,001)	43

	III. Net Inpatient Revenue detailed by Payer Source for each line		
44	Medicaid Fee for Service	\$ 78,102.00	44
45	Medicaid Managed Long Term Services and Supports (MLTSS)		45
46	MMAI-Medicaid is the Primary Payer		46
47	MMAI-Medicare is the Primary Payer	126,550.00	47
48	Private Pay	295,285.00	48
49	Medicare Part A	4,072,858.00	49
50	Other-(specify) Commercial Insurance Revenue	1,176,998.00	50
51	Other-(specify) Miscellaneous Revenue	255.00	51
52	Other-(specify)		52
53	Other-(specify)		53
54	Other-(specify)		54
55	Other-(specify)		55
56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,750,048	56

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	4,439	4,439	\$ 253,223	\$ 57.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,355	10,355	436,623	42.17	3
4	Licensed Practical Nurses	13,633	13,633	581,907	42.68	4
5	CNAs & Orderlies	28,597	28,597	732,813	25.63	5
6	CNA Trainees					6
7	Licensed Therapist	10,105	10,105	505,838	50.06	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,042	2,042	79,510	38.94	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	11,834	11,834	257,996	21.80	15
16	Dishwashers					16
17	Maintenance Workers	2,041	2,041	68,122	33.38	17
18	Housekeepers	11,579	11,579	188,205	16.25	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,949	3,949	176,411	44.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified ID Prof (QIDP)					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	2,000	2,000	50,473	25.24	33
34	TOTAL (lines 1 - 33)	100,574	100,574	\$ 3,331,121 *	\$ 33.12	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	2,000	\$ 75,316	1-3	35
36	Medical Director	108	13,988	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)	2,108	\$ 89,304		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.

XX. GENERAL INFORMATION:

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

No
- (2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.

Association Name	Amount
	Total
- (3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations.
The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.

	Total
- (4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)

	Total
- (5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V.

\$ 8,832 Line 10-2
- (6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes If NO, attach a complete explanation.
- (7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 48,000
- (8) 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.

- (9) 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
- (10) 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? 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.

No
- (11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ No Has any meal income been offset against related costs? No Indicate the amount. \$
- (12) 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
- (13) Has an audit been performed by an independent certified public accounting firm?

Firm Name: N/A

No
- (14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

N/A
- (15) 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.