

Facility Name & ID Number East Bank Center, L.L.C.

0047209 Report Period Beginning: 01/01/10 Ending: 12/31/10

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 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment				
		3 Medicaid Recipient	4 Private Pay	5 Other	6 Total	
8	SNF	65	3,971	8,654	12,690	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	65	3,971	8,654	12,690	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.38%

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

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

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

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

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 8,654

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/10 Fiscal Year: 12/31/10

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

Facility Name & ID Number East Bank Center, L.L.C. # 0047209 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	207,048	8,253	19,833	235,134		235,134		235,134		1
2	Food Purchase		118,641		118,641		118,641		118,641		2
3	Housekeeping	164,407	20,931	11,172	196,510		196,510		196,510		3
4	Laundry		3,549	317	3,866		3,866		3,866		4
5	Heat and Other Utilities			95,025	95,025		95,025	(16,873)	78,152		5
6	Maintenance	28,630		55,775	84,405		84,405		84,405		6
7	Other (specify):*										7
8	TOTAL General Services	400,085	151,374	182,122	733,581		733,581	(16,873)	716,708		8
	B. Health Care and Programs										
9	Medical Director			25,038	25,038		25,038		25,038		9
10	Nursing and Medical Records	1,432,755	167,679	33,327	1,633,761		1,633,761		1,633,761		10
10a	Therapy										10a
11	Activities	44,819		1,304	46,123		46,123		46,123		11
12	Social Services			4,163	4,163		4,163		4,163		12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,477,574	167,679	63,832	1,709,085		1,709,085		1,709,085		16
	C. General Administration										
17	Administrative	195,464			195,464		195,464		195,464		17
18	Directors Fees										18
19	Professional Services			46,512	46,512		46,512		46,512		19
20	Dues, Fees, Subscriptions & Promotions			9,556	9,556		9,556		9,556		20
21	Clerical & General Office Expenses	130,330	8,406	132,729	271,465		271,465		271,465		21
22	Employee Benefits & Payroll Taxes			360,951	360,951		360,951		360,951		22
23	Inservice Training & Education										23
24	Travel and Seminar			100	100		100		100		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			65,315	65,315		65,315		65,315		26
27	Other (specify):*	149,276		199,447	348,723		348,723	(348,723)			27
28	TOTAL General Administration	475,070	8,406	814,610	1,298,086		1,298,086	(348,723)	949,363		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,352,729	327,459	1,060,564	3,740,752		3,740,752	(365,596)	3,375,156		29

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

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

East Bank Center, L.L.C.

#0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

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			255,799	255,799		255,799		255,799			30
31	Amortization of Pre-Op. & Org.			1,218	1,218		1,218		1,218			31
32	Interest			506,135	506,135		506,135		506,135			32
33	Real Estate Taxes			24,847	24,847		24,847		24,847			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			787,999	787,999		787,999		787,999			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,637,242	1,637,242		1,637,242		1,637,242			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			32,978	32,978		32,978		32,978			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			1,670,220	1,670,220		1,670,220		1,670,220			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,352,729	327,459	3,518,783	6,198,971		6,198,971	(365,596)	5,833,375			45

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

VI. ADJUSTMENT DETAIL

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

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(16,873)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(134,266)	27		24
25	Fund Raising, Advertising and Promotional	(214,457)	27		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)	\$ (365,596)		\$	30

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (365,596)		37

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

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

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39	Outpatient Services		X	24,426	39	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		X	48,748	39	42
43	Prescription Drugs		X	536,268	39	43
44	Illinois Bed Tax		X	32,978	42	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 642,420		47

BHF USE ONLY

48		49		50		51		52	
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East Bank Center, L.L.C.

ID# 0047209

Report Period Beginning: 01/01/10

Ending: 12/31/10

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number East Bank Center, L.L.C.# 0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Operating Expenses	PAGES	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	(16,873)	0	0	0	0	0	0	0	0	0	0	(16,873)	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	(16,873)	0	(16,873)	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):*	(348,723)	0	0	0	0	0	0	0	0	0	0	(348,723)	27
28	TOTAL General Administration	(348,723)	0	(348,723)	28									
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(365,596)	0	(365,596)	29									

STATE OF ILLINOIS

Summary B

Facility Name & ID Number East Bank Center, L.L.C.# 0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

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

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
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)	(365,596)	0	0	0	0	0	0	0	0	0	0	(365,596)	45

Facility Name & ID Number

East Bank Center, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Attached Schedule		Home Bridge Center	Belvidere	Advanced Therapy Sol	Rockford	Therapy
				Transitions Hospice	Rockford	Hospice
				Axis Management	Rockford	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: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
1	V	39 Therapy Services	\$ 1,027,800	Advanced Therapy Solutions		\$ 1,027,800	\$	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		\$ 1,027,800			\$ 1,027,800	\$ *	14

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

Facility Name & ID Number

East Bank Center, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edna Atanacio	Admiss / Disch Coord	Admiss/Clerical	0.01	0	40	100.00	Wages	\$ 74,107	21-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 74,107		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, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending: 12/31/10

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

Facility Name & ID Number

East Bank Center, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

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										
										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	First Choice Bank		X	Mortgage	\$31,842.00	6/17/05	\$ 3,941,429	\$ 3,692,702	5/1/11	7.5500	\$ 286,555	1							
2	Nihan & Martin		X	Pharmeceutical Supplies	\$10,540.00	10/31/08	379,513	124,189	2/1/12	6.2500	21,969	2							
3	Advanced Management Co.	X		Operations	None		159,463	38,011	N/A			3							
4	S. Parekh	X		Operations	None		70,000	70,000	N/A	10.0000	7,000	4							
5												5							
Working Capital																			
6	Midwest Business Credit		X	Operating LOC	Interest only	2008	850,000	848,452	2012	floating	168,111	6							
7	Midwest Business Credit		X	Short term loan	\$15,000.00	2010	150,000	37,500	2011	floating	22,500	7							
8												8							
9	TOTAL Facility Related				\$57,382.00		\$ 5,550,405	\$ 4,810,854			\$ 506,135	9							
B. Non-Facility Related*																			
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$ 5,550,405	\$ 4,810,854			\$ 506,135	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 2009 report.		\$	24,137		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.)		\$	23,895		2
3. Under or (over) accrual (line 2 minus line 1).		\$	(242)		3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	25,089		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.		\$	24,847		7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	2005	21,880	8	FOR BHF USE ONLY	
	2006	21,292	9	13	FROM R. E. TAX STATEMENT FOR 2009 \$ 13
	2007	21,648	10	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	2008	22,988	11	15	LESS REFUND FROM LINE 6 \$ 15
	2009	23,895	12	16	AMOUNT TO USE FOR RATE CALCULATION \$ 16
Accrual at 12/31/10 is based on the 2009 tax bill, plus an increase factor.					

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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME East Bank Center, L.L.C. 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 2009 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 2009.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>11-01-252-012</u>	<u>Facility</u>	\$ <u>23,054.00</u>	\$ <u>23,054.00</u>
2.	<u>11-01-177-016</u>	<u>Land</u>	\$ <u>840.00</u>	\$ <u>840.00</u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS			\$ <u><u>23,894.00</u></u>	\$ <u><u>23,894.00</u></u>

B. Real Estate Tax Cost Allocations

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

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

C. Tax Bills

Attach a copy of the original 2009 tax bills which were listed in Section A to this statement. Be sure to use the 2009 tax bill which is normally paid during 2010.

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

Facility Name & ID Number East Bank Center, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

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).

None

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

Facility Name & ID Number East Bank Center, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	54		2005		\$ 844,430	\$ 21,652	39	\$ 21,652	\$	\$ 120,889	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Wings A, B, C, & Front										
10			2006		7,780	199	39	199		881	9
11			2006		79,134	2029	39	2029		8,961	10
12			2006		86,308	2213	39	2213		9,774	11
13			2006		33,784	866	39	866		3,825	12
14			2006		14,818	380	39	380		1,678	13
15			2006		33,589	861	39	861		3,803	14
16			2006		75,965	1948	39	1948		8,604	15
17			2006		44,426	1139	39	1139		5,031	16
18			2006		90,127	2311	39	2311		10,207	17
19			2006		54,849	1406	39	1406		6,210	18
20			2006		1,090	28	39	28		124	19
21			2006		13,298	341	39	341		1,506	20
22			2006		14,790	379	39	379		1,674	21
23			2006		35,828	919	39	919		4,059	22
24			2006		9,304	239	39	239		1,055	23
25			2006		23,275	597	39	597		2,637	24
26			2006		255,033	6540	39	6540		28,883	25
27			2006		64,445	1652	39	1652		7,296	26
28			2006		109,090	2797	39	2797		12,353	27
29			2006		25,000	641	39	641		2,831	28
30			2006		45,374	1163	39	1163		5,137	29
31			2006		6,000	154	39	154		680	30
32			2006		15,200	390	39	390		1,722	31
33			2006		10,957	281	39	281		1,241	32
34			2007		1,192	31	39	31		124	33
35			2007		2,196	56	39	56		224	34
36											35
											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, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$	\$ 465	37
38	Overhead & Fees	2007	79,626	2,042	39	2,042		7,657	38
39	General Requirements	2007	57,076	1,463	39	1,463		5,487	39
40	Demolition	2007	33,088	848	39	848		3,180	40
41	Site work / foundation	2007	33,459	858	39	858		3,217	41
42	Concrete	2007	31,185	800	39	800		3,000	42
43	Masonry	2007	28,416	729	39	729		2,733	43
44	Carpentry	2007	120,204	3,082	39	3,082		11,446	44
45	Joints & Sealers	2007	1,413	36	39	36		135	45
46	Doors, Frames & Hardware	2007	86,147	2,209	39	2,209		8,284	46
47	Drywall	2007	121,143	3,107	39	3,107		11,539	47
48	Special Finishing	2007	50,225	1,288	39	1,288		4,830	48
49	Insulation	2007	1,414	36	39	36		135	49
50	Architectural	2007	14,424	370	39	370		1,387	50
51	Paving	2007	750	19	39	19		71	51
52	Roofing	2007	11,367	291	39	291		1,092	52
53	Glass & Glazing	2007	22,608	580	39	580		2,175	53
54	Flooring	2007	55,767	1,430	39	1,430		5,362	54
55	Wall Coverings	2007	17,900	459	39	459		1,721	55
56	Fire Protection	2007	25,200	646	39	646		2,423	56
57	Plumbing	2007	233,029	5,975	39	5,975		22,294	57
58	HVAC	2007	106,700	2,736	39	2,736		10,260	58
59	Electrical	2007	172,039	4,411	39	4,411		16,541	59
60	Communication Systems	2007	24,857	637	39	637		2,389	60
61	Landscaping	2007	2,920	75	39	75		281	61
62	Signage	2007	5,875	839	7	839		3,147	62
63	Floor Tile	2007	4,774	123	39	123		439	63
64	Building Pipe	2007	2,463	63	39	63		226	64
65	Building Permit	2007	2,935	75	39	75		270	65
66	2 Doors	2007	1,575	40	39	40		141	66
67	Floor Tile	2007	4,336	111	39	111		388	67
68	Flooring	2007	5,495	141	39	141		482	68
69	Construction Interest	2007	254,781	6,533	39	6,533		21,232	69
70	TOTAL (lines 4 thru 69)		\$ 3,615,307	\$ 93,388		\$ 93,388	\$	\$ 405,838	70

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

Facility Name & ID Number East Bank Center, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-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	\$ 93,388		\$ 93,388	\$	\$ 405,838	1
2	Walk-in freezer	2007	10,281	1,469	7	1,469		4,652	2
3	Doors, & Fire Alarm	2007	7,577	194	39	194		598	3
4	Floor Tile	2008	2,358	60	39	60		180	4
5	Sprinklers	2008	11,969	307	39	307		845	5
6	Floor Tile	2008	8,368	214	39	214		572	6
7	Laminate Flooring	2008	7,562	194	39	194		501	7
8	Tile flooring - foyer	2009	4,261	109	39	109		164	8
9	Parking lot expansion	2009	26,860	689	39	689		804	9
10	Dining room floor	2009	9,167	235	39	235		254	10
11	Ductwork and registers for dining room	2009	6,500	166	39	166		180	11
12	Ceiling demo, new drywall and trimwork	2009	8,817	226	39	226		245	12
13	Electrical, lighting, trimwork, and installation	2009	25,639	657	39	657		712	13
14	Ceiling tiles	2009	11,256	289	39	289		313	14
15									15
16	Parking lot	2010	21,640	508	39	508		508	16
17	Water softener	2010	7,876	168	39	168		168	17
18	Dining room, office, receipt walls, trimwork	2010	36,998	711	39	711		711	18
19	Dining room, office, reception trim, ceiling, floor	2010	49,716	957	39	957		957	19
20	Reception desk, counters	2010	5,759	74	39	74		74	20
21	Reception, office carpeting	2010	11,377	146	39	146		146	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)		\$ 3,889,288	\$ 100,761		\$ 100,761	\$	\$ 418,422	34

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

Facility Name & ID Number East Bank Center, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-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	\$ 926,850	\$ 121,459	\$ 121,459	\$		\$ 705,864	71
72	Current Year Purchases	31,830	3,579	3,579			3,579	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 958,680	\$ 125,038	\$ 125,038	\$		\$ 709,443	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,897,968	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 225,799	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 225,799	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,127,865	85

**

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

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

G. Construction-in-Progress

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

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

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

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions. YES NO

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

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

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

15. Is Movable equipment rental included in building rental? _____

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

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

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

Fiscal Year Ending Annual Rent

12. _____ /2011 \$ _____

13. _____ /2012 \$ _____

14. _____ /2013 \$ _____

* 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.

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

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

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

\$

D. NUMBER OF CNAs TRAINED

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

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

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

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

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8	
			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	39-3	hrs		\$	43,193	\$	462,510	\$		43,193	\$		462,510	1	
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,799		51,390			4,799			51,390	2	
3	Licensed Recreational Therapist		hrs												3	
4	Licensed Physical Therapist	39-3	hrs			47,992		513,900			47,992			513,900	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 prescripts							536,268				536,268	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs												10	
11	Academic Education		hrs												11	
12	Other (specify): <u>Outpatient Services</u>	39-3								24,426				24,426	12	
13	Other (specify): <u>Lab Services</u>	39-3								48,748				48,748	13	
14	TOTAL				\$	95,984	\$	1,027,800	\$	609,442	95,984	\$	1,637,242	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.

Facility Name & ID Number East Bank Center, L.L.C.

0047209

Report Period Beginning: 01/01/10

Ending:

12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10

(last day of reporting year)

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

		1 Operating	2 After Consolidation*	
A. Current Assets				
1	Cash on Hand and in Banks	\$ (108,066)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 126,000)	1,244,581		3
4	Supply Inventory (priced at)	18,050		4
5	Short-Term Investments			5
6	Prepaid Insurance	99,469		6
7	Other Prepaid Expenses	10,773		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,264,807	\$	10
B. Long-Term Assets				
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	3,889,289		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	958,679		16
17	Accumulated Depreciation (book methods)	(1,127,865)		17
18	Deferred Charges	42,393		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)	11,685		22
23	Other(specify): <u>Goodwill</u>	244,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 4,068,181	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,332,988	\$	25

		1 Operating	2 After Consolidation*	
C. Current Liabilities				
26	Accounts Payable	\$ 939,569	\$	26
27	Officer's Accounts Payable	8,751		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	885,952		29
30	Accrued Salaries Payable	39,975		30
31	Accrued Taxes Payable (excluding real estate taxes)	160,103		31
32	Accrued Real Estate Taxes(Sch.IX-B)	25,089		32
33	Accrued Interest Payable	74,852		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
Other Current Liabilities(specify):				
36	<u>Other Accrued Expenses</u>	1,736		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,136,027	\$	38
D. Long-Term Liabilities				
39	Long-Term Notes Payable	124,189		39
40	Mortgage Payable	3,692,702		40
41	Bonds Payable			41
42	Deferred Compensation			42
Other Long-Term Liabilities(specify):				
43	<u>Due to affiliates</u>	96,332		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,913,223	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,049,250	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (716,262)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,332,988	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (851,231)	1
2	Restatements (describe):		2
3	Prior period adjustment	44	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (851,187)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	134,925	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)	\$ 134,925	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)	\$ (716,262)	24 *

* This must agree with page 17, line 47.

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

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

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,303,896	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,303,896	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)	\$ 6,303,896	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	733,581	31
32	Health Care	1,709,085	32
33	General Administration	1,296,808	33
B. Capital Expense			
34	Ownership	759,277	34
C. Ancillary Expense			
35	Special Cost Centers	1,670,220	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)*	\$ 6,168,971	40
41	Income before Income Taxes (line 30 minus line 40)**	134,925	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 134,925	43

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number East Bank Center, L.L.C.

0047209

Report Period Beginning:

01/01/10

Ending:

12/31/10

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,048	1,048	\$ 53,942	\$ 51.47	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,310	17,310	510,241	29.48	3
4	Licensed Practical Nurses	20,142	20,142	456,100	22.64	4
5	CNAs & Orderlies	33,793	33,793	412,472	12.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,160	2,160	41,704	19.31	9
10	Activity Assistants					10
11	Social Service Workers	144	144	3,115	21.63	11
12	Dietician					12
13	Food Service Supervisor	2,969	2,969	63,161	21.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,567	14,567	143,887	9.88	15
16	Dishwashers					16
17	Maintenance Workers	2,007	2,007	28,630	14.27	17
18	Housekeepers	15,128	15,128	164,407	10.87	18
19	Laundry					19
20	Administrator	4,400	4,400	195,464	44.42	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,640	1,640	21,794	13.29	23
24	Clerical	6,535	6,535	108,536	16.61	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) <u>Marketing</u>	4,320	4,320	149,276	34.55	33
34	TOTAL (lines 1 - 33)	126,163	126,163	\$ 2,352,729 *	\$ 18.65	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	620	\$ 18,646	1-3	35
36	Medical Director	310	25,038	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)	930	\$ 43,684		49

C. CONTRACT NURSES

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

Facility Name & ID Number East Bank Center, L.L.C.

0047209

Report Period Beginning: 01/01/10

Ending: 12/31/10

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Assoc \$1,995
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,206 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 32,978
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.