

Facility Name & ID Number East Bank Center LLC

0047209 Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	2	3,721	7,410	11,133	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	2	3,721	7,410	11,133	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 56.48%

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 7,410

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number

East Bank Center LLC

0047209

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	171,279		24,122	195,401		195,401	195,401			1
2	Food Purchase		166,115		166,115		166,115	166,115			2
3	Housekeeping	161,583	21,442	7,380	190,405		190,405	190,405			3
4	Laundry		4,029		4,029		4,029	4,029			4
5	Heat and Other Utilities			68,433	68,433		68,433	68,433			5
6	Maintenance	3,000		66,095	69,095		69,095	69,095			6
7	Other (specify):*										7
8	TOTAL General Services	335,862	191,586	166,030	693,478		693,478	693,478			8
	B. Health Care and Programs										
9	Medical Director			38,382	38,382		38,382	38,382			9
10	Nursing and Medical Records	1,237,148	120,898	29,344	1,387,390		1,387,390	1,387,390			10
10a	Therapy	799,855			799,855		799,855	799,855			10a
11	Activities	68,630	1,685	2,144	72,459		72,459	72,459			11
12	Social Services			1,619	1,619		1,619	1,619			12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,105,633	122,583	71,489	2,299,705		2,299,705	2,299,705			16
	C. General Administration										
17	Administrative	123,831			123,831		123,831	123,831			17
18	Directors Fees										18
19	Professional Services			30,497	30,497		30,497	30,497			19
20	Dues, Fees, Subscriptions & Promotions			17,620	17,620		17,620	17,620			20
21	Clerical & General Office Expenses	306,851	23,129	131,304	461,284		461,284	461,284			21
22	Employee Benefits & Payroll Taxes			448,118	448,118		448,118	448,118			22
23	Inservice Training & Education										23
24	Travel and Seminar			49,126	49,126		49,126	49,126			24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			90,040	90,040		90,040	90,040			26
27	Other (specify):* marketing / promo	60,852		212,771	273,623		273,623	273,623			27
28	TOTAL General Administration	491,534	23,129	979,476	1,494,139		1,494,139	1,494,139			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,933,029	337,298	1,216,995	4,487,322		4,487,322	4,487,322			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 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
	D. Ownership										
30	Depreciation			116,559	116,559		116,559	116,559			30
31	Amortization of Pre-Op. & Org.			1,217	1,217		1,217	1,217			31
32	Interest			444,221	444,221		444,221	444,221			32
33	Real Estate Taxes			26,880	26,880		26,880	26,880			33
34	Rent-Facility & Grounds										34
35	Rent-Equipment & Vehicles										35
36	Other (specify):*										36
37	TOTAL Ownership			588,877	588,877		588,877	588,877			37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation										38
39	Ancillary Service Centers			571,602	571,602		571,602	571,602			39
40	Barber and Beauty Shops										40
41	Coffee and Gift Shops										41
42	Provider Participation Fee			56,040	56,040		56,040	56,040			42
43	Other (specify):*										43
44	TOTAL Special Cost Centers			627,642	627,642		627,642	627,642			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,933,029	337,298	2,433,514	5,703,841		5,703,841	5,703,841			45

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

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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	(7,515)			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	(187,637)			24
25	Fund Raising, Advertising and Promotional	(85,985)			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)	\$ (281,137)		\$	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)	\$ (281,137)		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	26,676	39	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		X	51,562	39	42
43	Prescription Drugs		X	493,364	39	43
44	Illinois Bed Tax/Assessment		X	56,040	42	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$ 627,642		47

BHF USE ONLY						
48		49		50		51
						52

East Bank Center LLC

ID# 0047209

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

Sch. V Line

NON-ALLOWABLE EXPENSES

Amount

Reference

1		\$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		0	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	0	0	0	0	0	0	0	0	0	0	0	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning:

01/01/2015 Ending:

Summary B

12/31/2015

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
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	0	0	0	0	0	0	0	0	0	0	0	0	45

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Advanced Management Co. LLC	65.36					
U. Parekh	31.67			Transitions Hospice	Huntley	Hospice
E. Atanacio	1.49			Advantage Medical Eq	Huntley	DME and Supplies
P. Tabieros	0.74			Axis Management	Huntley	Management Svcs
V. Tabieros	0.74					

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	10 DME and Supplies	\$ 22,270	Advantage Medical Equipment		\$ 22,270	\$	1
2	V							2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 22,270			\$ 22,270	\$ *	14

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

VII. RELATED PARTIES

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

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

Facility Name & ID Number

East Bank Center LLC

#

0047209

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

VII. RELATED PARTIES (continued)

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

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

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edna Atanacio	Activities/Admiss/Disc	Activities/Admin	0.01	0	40	100.00	wages	\$ 68,630	11-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 68,630		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: 01/01/2015

Ending: 2/31/2015

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

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

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

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 LLC

0047209

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	Name of Lender	2		3	4	5	6		8	9	10	11						
		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	Amresco		X	Mortgage	\$35,000.00	6/17/05	\$ 3,941,429	\$ 3,655,960	7/31/17	7.5500	\$ 299,522	1						
2	Amresco		X	Mortgage/Operations	\$6,500.00	11/4/14	152,000	89,701	7/31/17	12.0000	14,471	2						
3	Advanced Management Co.	X		Operations	None		159,463	38,011				3						
4	S. Parekh	X		Operations	None		70,000	70,000			7,000	4						
5	J. Palazzo	X		Operations	None		8,751	8,751				5						
Working Capital																		
6	U. Parekh	X		Working Capital/LOC	None	11/5/14	250,000	250,000	11/20/16	10.0000	25,000	6						
7	Aadiyat Business Resources		X	Working Capital	\$1,095.00	7/10/14	68,310	6,090	6/1/16	11.0000	6,300	7						
8	U. Parekh & Other ST loans	X		Working Capital	interest	var	var	262,426	var	var	91,928	8						
9	TOTAL Facility Related				\$42,595.00		\$ 4,649,953	\$ 4,380,939			\$ 444,221	9						
B. Non-Facility Related*																		
10												10						
11												11						
12												12						
13												13						
14	TOTAL Non-Facility Related						\$	\$			\$	14						
15	TOTALS (line 9+line14)						\$ 4,649,953	\$ 4,380,939			\$ 444,221	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 2014 report.		\$	<u>28,240</u>	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.)		\$	<u>26,888</u>	2											
3. Under or (over) accrual (line 2 minus line 1).		\$	<u>(1,352)</u>	3											
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	<u>28,232</u>	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.		\$	<u>26,880</u>	7											
Real Estate Tax History:															
Real Estate Tax Bill for Calendar Year:	2010	<u>25,024</u>	8	<table border="1" style="width: 100%;"> <tr> <td colspan="2" style="text-align: center;">FOR BHF USE ONLY</td> </tr> <tr> <td style="text-align: center;">13</td> <td>FROM R. E. TAX STATEMENT FOR 2014 \$</td> </tr> <tr> <td style="text-align: center;">14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> </tr> <tr> <td style="text-align: center;">15</td> <td>LESS REFUND FROM LINE 6 \$</td> </tr> <tr> <td style="text-align: center;">16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> </tr> </table>		FOR BHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2014 \$	14	PLUS APPEAL COST FROM LINE 5 \$	15	LESS REFUND FROM LINE 6 \$	16	AMOUNT TO USE FOR RATE CALCULATION \$
FOR BHF USE ONLY															
13	FROM R. E. TAX STATEMENT FOR 2014 \$														
14	PLUS APPEAL COST FROM LINE 5 \$														
15	LESS REFUND FROM LINE 6 \$														
16	AMOUNT TO USE FOR RATE CALCULATION \$														
	2011	<u>25,423</u>	9												
	2012	<u>26,158</u>	10												
	2013	<u>26,895</u>	11												
	2014	<u>26,888</u>	12												

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.

2014 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME East Bank Center LLC COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0047209

CONTACT PERSON REGARDING THIS REPORT James Dale

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

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2014 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 2014.

(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>25,942.00</u>	\$ <u>25,942.00</u>
2. <u>11-01-177-016</u>	<u>Land</u>	\$ <u>946.00</u>	\$ <u>946.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>26,888.00</u></u>	\$ <u><u>26,888.00</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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

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

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

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

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

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

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

XI. OWNERSHIP COSTS:

A. Land.

	1 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>	1
2					2
3	TOTALS	15,000		\$ 50,000	3

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9		
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	54	2005		\$ 844,430	\$ 21,652	39	\$ 21,652	\$	\$ 229,151	4
5										5
6										6
7										7
8										8
Improvement Type**										
9	Building Wings A, B, C, & Front									9
10	Insurance	2006		7,780	199	39	199		1,876	10
11	Overhead & Fee	2006		79,134	2029	39	2029		19,106	11
12	General Requirements	2006		86,308	2213	39	2213		20,839	12
13	Demolition	2006		33,784	866	39	866		8,155	13
14	Concrete	2006		14,818	380	39	380		3,578	14
15	Masonry	2006		33,589	861	39	861		8,108	15
16	Carpentry	2006		75,965	1948	39	1948		18,344	16
17	Doors Frames, Hardware	2006		44,426	1139	39	1139		10,726	17
18	Drywall	2006		90,127	2311	39	2311		21,762	18
19	Architectural Design	2006		54,849	1406	39	1406		13,240	19
20	Insulation	2006		1,090	28	39	28		264	20
21	Roofing	2006		13,298	341	39	341		3,211	21
22	Glass & Glazing	2006		14,790	379	39	379		3,569	22
23	Flooring	2006		35,828	919	39	919		8,654	23
24	Painting	2006		9,304	239	39	239		2,250	24
25	Fire Protection	2006		23,275	597	39	597		5,622	25
26	Plumbing	2006		255,033	6541	39	6541		61,586	26
27	HVAC	2006		64,445	1652	39	1652		15,556	27
28	Electric	2006		109,090	2797	39	2797		26,339	28
29	Communications Systems	2006		25,000	641	39	641		6,036	29
30	Extinguishers, railings, lighting	2006		45,374	1163	39	1163		10,952	30
31	water hookup	2006		6,000	154	39	154		1,450	31
32	site work	2006		15,200	390	39	390		3,672	32
33	wall lamps	2006		10,957	281	39	281		2,646	33
34	Painting	2007		1,192	31	39	31		279	34
35	Glass	2007		2,196	56	39	56		503	35
36										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:

01/01/2015 Ending: 12/31/2015

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Insurance	2007	\$ 4,834	\$ 124	39	\$ 124	\$	\$ 1,085	37
38	Overhead & Fees	2007	79,626	2,042	39	2,042		17,866	38
39	General Requirements	2007	57,076	1,463	39	1,463		12,802	39
40	Demolition	2007	33,088	848	39	848		7,420	40
41	Site work / foundation	2007	33,459	858	39	858		7,507	41
42	Concrete	2007	31,185	800	39	800		7,000	42
43	Masonry	2007	28,416	729	39	729		6,378	43
44	Carpentry	2007	120,204	3,081	39	3,081		26,853	44
45	Joints & Sealers	2007	1,413	36	39	36		315	45
46	Doors, Frames & Hardware	2007	86,147	2,209	39	2,209		19,329	46
47	Drywall	2007	121,143	3,107	39	3,107		27,073	47
48	Special Finishing	2007	50,225	1,288	39	1,288		11,270	48
49	Insulation	2007	1,414	36	39	36		315	49
50	Architectural	2007	14,424	370	39	370		3,237	50
51	Paving	2007	750	19	39	19		166	51
52	Roofing	2007	11,367	291	39	291		2,547	52
53	Glass & Glazing	2007	22,608	580	39	580		5,075	53
54	Flooring	2007	55,767	1,430	39	1,430		12,512	54
55	Wall Coverings	2007	17,900	459	39	459		4,016	55
56	Fire Protection	2007	25,200	646	39	646		5,653	56
57	Plumbing	2007	233,029	5,975	39	5,975		52,170	57
58	HVAC	2007	106,700	2,736	39	2,736		23,940	58
59	Electrical	2007	172,039	4,412	39	4,412		38,599	59
60	Communication Systems	2007	24,857	637	39	637		5,574	60
61	Landscaping	2007	2,920	75	39	75		656	61
62	Signage	2007	5,875	75	7			5,875	62
63	Floor Tile	2007	4,774	123	39	123		1,053	63
64	Building Pipe	2007	2,463	63	39	63		541	64
65	Building Permit	2007	2,935	75	39	75		645	65
66	2 Doors	2007	1,575	40	39	40		344	66
67	Floor Tile	2007	4,336	111	39	111		944	67
68	Flooring	2007	5,495	141	39	141		1,186	68
69	Construction Interest	2007	254,781	6,533	39	6,533		53,896	69
70	TOTAL (lines 4 thru 69)		\$ 3,615,307	\$ 92,550		\$ 92,550	\$	\$ 871,316	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:

01/01/2015 Ending: 12/31/2015

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 3,615,307	\$ 92,550		\$ 92,550	\$	\$ 871,316	1
2	Walk-in freezer	2007	10,281		7			10,281	2
3	Doors, & Fire Alarm	2007	7,577	194	39	194		1,570	3
4	Floor Tile	2008	2,358	60	39	60		484	4
5	Sprinklers	2008	11,969	307	39	307		2,379	5
6	Floor Tile	2008	8,368	215	39	215		1,645	6
7	Laminate Flooring	2008	7,562	193	39	193		1,470	7
8	Tile flooring - foyer	2009	4,261	109	39	109		710	8
9	Parking lot expansion	2009	26,860	689	39	689		4,247	9
10	Dining room floor	2009	9,167	235	39	235		1,430	10
11	Ductwork and registers for dining room	2009	6,500	167	39	167		1,014	11
12	Ceiling demo, new drywall and trimwork	2009	8,817	226	39	226		1,375	12
13	Electrical, lighting, trimwork, and installation	2009	25,639	657	39	657		3,999	13
14	Ceiling tiles	2009	11,256	289	39	289		1,756	14
15	Parking lot	2010	21,640	555	39	555		3,283	15
16	Water softener	2010	7,876	202	39	202		1,178	16
17	Dining room, office, receipt walls, trimwork	2010	36,998	948	39	948		5,454	17
18	Dining room, office, reception trim, ceiling, floor	2010	49,716	1,275	39	1,275		7,330	18
19	Reception desk, counters	2010	5,759	148	39	148		813	19
20	Reception, office carpeting	2010	11,377	292	39	292		1,605	20
21									21
22	Electrical raceway, control	2011	8,146	209	39	209		1,027	22
23	Electrical, lighting	2011	3,820	98	39	98		457	23
24	Front office trimwork	2011	1,750	45	39	45		209	24
25	Parking lot	2011	18,000	461	39	461		2,076	25
26	Flooring for patient rooms	2011	5,649	145	39	145		640	26
27									27
28	Front office trimwork	2012	2,127	55	39	55		218	28
29	Therapy Counter	2012	1,015	26	39	26		102	29
30	Therapy Flooring	2012	2,927	75	39	75		281	30
31	Railing & Fence for Stairs	2012	2,403	62	39	62		200	31
32	Water Heaters	2013	12,800	328	39	328		875	32
33	Electrical Panel/breaker/run	2013	14,653	376	39	376		1,002	33
34	TOTAL (lines 1 thru 33)		\$ 3,962,578	\$ 101,191		\$ 101,191	\$	\$ 930,426	34

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

XI. OWNERSHIP COSTS (continued)

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

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 3,962,578	\$ 101,191		\$ 101,191	\$	\$ 930,426	1
2	Dr. Office Trimwork	2014	2,481	64	39	64		122	2
3	Capitalized Interest	2014	2,872	74	39	74		129	3
4	Trees	2014	2,000	51	39	51		81	4
5	Hallway Carpeting	2014	16,000	410	39	410		479	5
6	Boiler	2014	3,780	97	39	97		105	6
7									7
8	Boiler	2015	4,400	75	39	75		75	8
9	Boiler Pump	2015	1,151	12	39	12		12	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	TOTAL (lines 1 thru 33)		\$ 3,995,262	\$ 101,974		\$ 101,974	\$	\$ 931,429	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	\$ 1,009,514	\$ 14,283	\$ 14,283	\$		\$ 984,623	71
72	Current Year Purchases	4,324	302	302			302	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,013,838	\$ 14,585	\$ 14,585	\$		\$ 984,925	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)	\$ 5,059,100	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 116,559	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 116,559	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)	\$ 1,916,354	85

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

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

G. Construction-in-Progress

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

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

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

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning: 01/01/2015

Ending: 12/31/2015

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

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. _____ /2016 \$ _____

13. _____ /2017 \$ _____

14. _____ /2018 \$ _____

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

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

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

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

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ _____ Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

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

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2015 Ending: 12/31/2015
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?</p> <p><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. CLASSROOM PORTION:</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. CLINICAL PORTION:</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	10-a1	9,413	hrs	\$ 359,935		\$	\$	9,413	\$ 359,935	1
2	Licensed Speech and Language Development Therapist	10-a1	1,046	hrs	39,993				1,046	39,993	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10-a1	10,459	hrs	399,927				10,459	399,927	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				493,364		493,364	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						26,676		26,676	12
13	Other (specify): <u>Lab Services</u>	39-3						51,562		51,562	13
14	TOTAL				\$ 799,855		\$	\$ 571,602	20,918	\$ 1,371,457	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 LLC# 0047209Report Period Beginning: 01/01/2015

Ending:

12/31/2015

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2015

(last day of reporting year)

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

		1	2	
		Operating	After	
			Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (17,151)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>127,000</u>)	1,118,157		3
4	Supply Inventory (priced at)	15,967		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,003		6
7	Other Prepaid Expenses	156,767		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,292,743	\$	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	3,995,262		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,013,838		16
17	Accumulated Depreciation (book methods)	(1,916,354)		17
18	Deferred Charges	14,306		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spec <u>Deposits</u>)	11,685		22
23	Other(specify): <u>Goodwill</u>	244,000		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,412,737	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,705,480	\$	25

		1	2	
		Operating	After	
			Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,244,295	\$	26
27	Officer's Accounts Payable	8,751		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	277,267		29
30	Accrued Salaries Payable	128,110		30
31	Accrued Taxes Payable (excluding real estate taxes)	632,474		31
32	Accrued Real Estate Taxes(Sch.IX-B)	28,232		32
33	Accrued Interest Payable	74,551		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Other Accrued Expenses</u>	65,093		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,458,773	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	447,712		39
40	Mortgage Payable	3,655,960		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)	\$ 4,103,672	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 6,562,445	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,856,965)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,705,480	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,733,033)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,733,033)	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(123,932)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (123,932)	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,856,965)	24 *

* This must agree with page 17, line 47.

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

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

		1	2
I. Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 5,579,909	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,579,909	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)	\$ 5,579,909	30

		1	2
II. Expenses		Amount	
A. Operating Expenses			
31	General Services	693,478	31
32	Health Care	2,299,705	32
33	General Administration	1,494,139	33
B. Capital Expense			
34	Ownership	588,877	34
C. Ancillary Expense			
35	Special Cost Centers	571,602	35
36	Provider Participation Fee	56,040	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,703,841	40
41	Income before Income Taxes (line 30 minus line 40)**	(123,932)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (123,932)	43

III. Net Inpatient Revenue detailed by Payer Source		1	2
44	Medicaid - Net Inpatient Revenue	\$ 4,264	44
45	Private Pay - Net Inpatient Revenue	193,875	45
46	Medicare - Net Inpatient Revenue	3,914,651	46
47	Other-(specify) <u>Private Insurance Revenue</u>	1,465,777	47
48	Other-(specify) <u>Miscellaneous Revenue</u>	1,342	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 5,579,909	49

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

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

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

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

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning:

01/01/2015

Ending:

12/31/2015

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	1,857	1,857	\$ 76,489	\$ 41.19	1
2	Assistant Director of Nursing					2
3	Registered Nurses	17,037	17,037	536,833	31.51	3
4	Licensed Practical Nurses	12,561	12,561	320,066	25.48	4
5	CNAs & Orderlies	27,200	27,200	303,760	11.17	5
6	CNA Trainees					6
7	Licensed Therapist	22,028	22,028	799,855	36.31	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	68,630	33.00	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	43,255	20.80	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,628	12,628	128,024	10.14	15
16	Dishwashers					16
17	Maintenance Workers	136	136	3,000	22.06	17
18	Housekeepers	13,330	13,330	161,583	12.12	18
19	Laundry					19
20	Administrator	1,880	1,880	123,831	65.87	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,080	2,080	30,240	14.54	23
24	Clerical	7,862	7,862	276,611	35.18	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>	1,960	1,960	60,852	31.05	33
34	TOTAL (lines 1 - 33)	124,719	124,719	\$ 2,933,029 *	\$ 23.52	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	410	\$ 22,116	1-3	35
36	Medical Director	325	38,382	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	37	1,619	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	772	\$ 62,117		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Lynn Erickson	Administrator	0	\$ 60,577	Workers' Compensation Insurance	\$ 78,601	IDPH License Fee	\$ 0	
Katherine Hansen	Administrator	0	6,923	Unemployment Compensation Insurance	27,019	Advertising: Employee Recruitment	6,196	
Patrick Scales	Administrator	0	56,331	FICA Taxes	243,172	Health Care Worker Background Check		
				Employee Health Insurance	43,293	(Indicate # of checks performed 91)	0	
				Employee Meals		Patient Background Checks	381 3,188	
				Illinois Municipal Retirement Fund (IMRF)*		Fingerprinting	1,930	
				Retirement Plan Contributions	29,285	Marketing/Promotion/Public Relations	85,985	
				Disability insurance	24,217	Licenses / Permits	6,306	
				Miscellaneous	2,531			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
			\$ 123,831			Less: Public Relations Expense	(85,985)	
B. Administrative - Other						Non-allowable advertising	()	
Description			Amount			Yellow page advertising	()	
			\$					
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Hovde & Tufo	Legal		\$ 13,000			\$	Out-of-State Travel	\$
Wipfli CPA's	Accounting		1,920					
R. Peelo & Associates	Cost Reporting		3,750					
S. Haugh	Billing		3,000				In-State Travel	35,869
Mankus & Marchan LLP	Accounting		6,368				Gasoline	9,009
Rockford Mercantile Exchange	Collections		202					
Other	Other		2,257				Seminar Expense	4,248
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 30,497	TOTAL		\$	Entertainment Expense	()
							(agree to Sch. V, line 24, col. 8)	
							TOTAL	\$ 49,126

* Attach copy of IMRF notifications

**See instructions.

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

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

Facility Name & ID Number East Bank Center LLC

0047209

Report Period Beginning: 01/01/2015 Ending: 12/31/2015

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? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? 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. \$ 3,685 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 56,040
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? No Indicate the amount. \$ 0
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? N/A
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? N/A
- (19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Yes
Attach invoices and a summary of services for all architect and appraisal fees.