FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2011
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2011)

I. IDPH License ID Number: 0047209

Facility Name: East Bank Center LLC

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

County: Winnebago

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

HFS ID Number:

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

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James Dale **Telephone Number:** (815) 637-2200
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) James M. Palazzo
(Title) Manager

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 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: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	66	3,417	9,163	12,646	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66	3,417	9,163	12,646	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.16%

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 [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

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 [X] Date 06/15/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 54 and days of care provided 9,163

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

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

Tax Year: 12/31/11 Fiscal Year: 12/31/11

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

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	185,350	9,303	5,934	200,587		200,587		200,587			1
2	Food Purchase		119,517		119,517		119,517		119,517			2
3	Housekeeping	164,956	20,520	6,702	192,178		192,178		192,178			3
4	Laundry		12,913		12,913		12,913		12,913			4
5	Heat and Other Utilities			87,019	87,019		87,019	(16,071)	70,948			5
6	Maintenance	924		112,919	113,843		113,843		113,843			6
7	Other (specify):*											7
8	TOTAL General Services	351,230	162,253	212,574	726,057		726,057	(16,071)	709,986			8
	B. Health Care and Programs											
9	Medical Director			14,637	14,637		14,637		14,637			9
10	Nursing and Medical Records	1,423,115	223,778	84,590	1,731,483		1,731,483		1,731,483			10
10a	Therapy											10a
11	Activities	36,003		3,176	39,179		39,179		39,179			11
12	Social Services			3,541	3,541		3,541		3,541			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,459,118	223,778	105,944	1,788,840		1,788,840		1,788,840			16
	C. General Administration											
17	Administrative	218,533			218,533		218,533		218,533			17
18	Directors Fees											18
19	Professional Services			63,270	63,270		63,270		63,270			19
20	Dues, Fees, Subscriptions & Promotions			10,905	10,905		10,905		10,905			20
21	Clerical & General Office Expenses	159,437	25,521	119,336	304,294		304,294		304,294			21
22	Employee Benefits & Payroll Taxes			355,610	355,610		355,610		355,610			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,231	9,231		9,231		9,231			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,952	93,952		93,952		93,952			26
27	Other (specify):*	145,761		47,827	193,588		193,588	(193,588)				27
28	TOTAL General Administration	523,731	25,521	700,131	1,249,383		1,249,383	(193,588)	1,055,795			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,334,079	411,552	1,018,649	3,764,280		3,764,280	(209,659)	3,554,621			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 LLC #0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			223,140	223,140		223,140		223,140			30
31	Amortization of Pre-Op. & Org.			1,217	1,217		1,217		1,217			31
32	Interest			527,192	527,192		527,192		527,192			32
33	Real Estate Taxes			26,210	26,210		26,210		26,210			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			777,759	777,759		777,759		777,759			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,763,408	1,763,408		1,763,408		1,763,408			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			30,766	30,766		30,766		30,766			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			1,794,174	1,794,174		1,794,174		1,794,174			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,334,079	411,552	3,590,582	6,336,213		6,336,213	(209,659)	6,126,554			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: 01/01/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(16,071)	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	(5,698)	27		24
25	Fund Raising, Advertising and Promotional	(187,890)	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)**	$ (209,659)		$	30

BHF USE ONLY								
48		49		50		51		52	

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

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (209,659)		37

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

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

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39	**Outpatient Services**		X	43,259	39	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		X	97,348	39	42
43	Prescription Drugs		X	526,321	39	43
44	Illinois Bed Tax		X	30,764	42	44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 697,692		47

East Bank Center LLC

ID# 0047209

Report Period Beginning: 01/01/11

Ending: 12/31/11

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

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number East Bank Center LLC **#** 0047209 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Operating Expenses	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)	
	A. General Services													
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	(16,071)	0	0	0	0	0	0	0	0	0	0	(16,071)	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**	(16,071)	0	0	0	0	0	0	0	0	0	0	(16,071)	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):*	(193,588)	0	0	0	0	0	0	0	0	0	0	(193,588)	27
28	**TOTAL General Administration**	(193,588)	0	0	0	0	0	0	0	0	0	0	(193,588)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(209,659)	0	0	0	0	0	0	0	0	0	0	(209,659)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number East Bank Center LLC **#** 0047209 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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

	Capital Expense D. Ownership	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)	
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)**	(209,659)	0	0	0	0	0	0	0	0	0	0	(209,659)	45

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Attached Schedule		Home Bridge Center	Belvidere	Advanced Therapy Sol	Rockford	Therapy
				Transitions Hospice	Huntley	Hospice
				Advantage Medical Eq	Huntley	DME and supplies
				Axis Management	Huntley	Management Svcs

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] 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 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	39	Therapy Services	$ 1,096,480	Advanced Therapy Solutions		$ 1,096,480	$	1
2	V								2
3	V	10	DME and supplies	159,081	Advantage Medical Equipment		159,081		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			$ 1,255,561			$ 1,255,561	$ *	14

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

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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: 01/01/11 Ending: 12/31/11

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	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Edna Atanacio	Admiss/Disch Coord	Admiss/Clerical	0.01	0	40	100.00	Wages	$ 74,164	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	$ 74,164		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: 01/01/11 Ending: 12/31/11

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 [X]

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 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	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: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Inland Bank		X	Mortgage	$31,842.00	06/17/05	$ 3,941,429	$ 3,599,417	11/12	7.5500	$ 288,814	1
2	Nihan & Martin		X	Pharmeceutical Supplies	$10,540.00	10/31/08	379,513	1,668	2/1/12	6.2500	12,922	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	Aadiyat Business Resources		X	Operations	$5,075.00	10/31/11	100,000	93,077	10/31/13	19.0000	3,527	5
	Working Capital											
6	Midwest Business Credit		X	Operating LOC	Interest Only	2008	850,000	839,554	2012	floating	196,094	6
7	Midwest Business Credit		X	Short Term Loan	$15,000.00	2010	150,000		2011	floating	7,500	7
8	Other miscellaneous interest										11,335	8
9	TOTAL Facility Related				$62,457.00		$ 5,650,405	$ 4,641,727			$ 527,192	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,650,405	$ 4,641,727			$ 527,192	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.)**

Facility Name & ID Number East Bank Center LLC **#** 0047209 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 25,089	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 25,024	2
3. Under or (over) accrual (line 2 minus line 1).		$ (65)	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 26,275	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.		$ 26,210	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2006	21,292	8
	2007	21,648	9
	2008	22,988	10
	2009	23,895	11
	2010	25,024	12

FOR BHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2010	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2010 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 2010 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 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-01-252-012	Facility	$ 24,144.00	$ 24,144.00
2.	11-01-177-016	Land	$ 880.00	$ 880.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 25,024.00	$ 25,024.00

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

Attach a copy of the original 2010 tax bills which were listed in Section A to this statement. Be sure to use the 2010 tax bill which is normally paid during 2011.

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 LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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? [X] (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? [X] (a) Own the Equipment [X] (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 [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

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

XI. OWNERSHIP COSTS:

A. Land.

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

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		2005		$ 844,430	$ 21,652	39	$ 21,652	$	$ 142,543	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		1,080	10
11	Overhead& Fee			2006	79,134	2029	39	2029		10,990	11
12	General Requirements			2006	86,308	2213	39	2213		11,987	12
13	Demolition			2006	33,784	866	39	866		4,691	13
14	Concrete			2006	14,818	380	39	380		2,058	14
15	Masonary			2006	33,589	861	39	861		4,664	15
16	Carpentry			2006	75,965	1948	39	1948		10,552	16
17	Doors Frames, Hardware			2006	44,426	1139	39	1139		6,170	17
18	Drywall			2006	90,127	2311	39	2311		12,518	18
19	Architectural Design			2006	54,849	1406	39	1406		7,616	19
20	Insulation			2006	1,090	28	39	28		152	20
21	Roofing			2006	13,298	341	39	341		1,847	21
22	Glass & Glazing			2006	14,790	379	39	379		2,053	22
23	Flooring			2006	35,828	919	39	919		4,978	23
24	Painting			2006	9,304	239	39	239		1,294	24
25	Fire Protection			2006	23,275	597	39	597		3,234	25
26	Plumbing			2006	255,033	6540	39	6540		35,423	26
27	HVAC			2006	64,445	1652	39	1652		8,948	27
28	Electric			2006	109,090	2797	39	2797		15,150	28
29	Communications Systems			2006	25,000	641	39	641		3,472	29
30	Extinguishers, railings, lighting			2006	45,374	1163	39	1163		6,300	30
31	water hookup			2006	6,000	154	39	154		834	31
32	site work			2006	15,200	390	39	390		2,112	32
33	wall lamps			2006	10,957	281	39	281		1,522	33
34	Painting			2007	1,192	31	39	31		155	34
35	Glass			2007	2,196	56	39	56		280	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Insurance	2007	$ 4,834	$ 124	39	$ 124	$	$ 589	37
38	Overhead & Fees	2007	79,626	2,042	39	2,042		9,699	38
39	General Requirements	2007	57,076	1,463	39	1,463		6,950	39
40	Demolition	2007	33,088	848	39	848		4,028	40
41	Site work / foundation	2007	33,459	858	39	858		4,075	41
42	Concrete	2007	31,185	800	39	800		3,800	42
43	Masonry	2007	28,416	729	39	729		3,462	43
44	Carpentry	2007	120,204	3,082	39	3,082		14,528	44
45	Joints & Sealers	2007	1,413	36	39	36		171	45
46	Doors, Frames & Hardware	2007	86,147	2,209	39	2,209		10,493	46
47	Drywall	2007	121,143	3,107	39	3,107		14,646	47
48	Special Finishing	2007	50,225	1,288	39	1,288		6,118	48
49	Insulation	2007	1,414	36	39	36		171	49
50	Architectural	2007	14,424	370	39	370		1,757	50
51	Paving	2007	750	19	39	19		90	51
52	Roofing	2007	11,367	291	39	291		1,383	52
53	Glass & Glazing	2007	22,608	580	39	580		2,755	53
54	Flooring	2007	55,767	1,430	39	1,430		6,792	54
55	Wall Coverings	2007	17,900	459	39	459		2,180	55
56	Fire Protection	2007	25,200	646	39	646		3,069	56
57	Plumbing	2007	233,029	5,975	39	5,975		28,269	57
58	HVAC	2007	106,700	2,736	39	2,736		12,996	58
59	Electrical	2007	172,039	4,411	39	4,411		20,952	59
60	Communication Systems	2007	24,857	637	39	637		3,026	60
61	Landscaping	2007	2,920	75	39	75		356	61
62	Signage	2007	5,875	839	7	839		3,986	62
63	Floor Tile	2007	4,774	123	39	123		562	63
64	Building Pipe	2007	2,463	63	39	63		289	64
65	Building Permit	2007	2,935	75	39	75		345	65
66	2 Doors	2007	1,575	40	39	40		181	66
67	Floor Tile	2007	4,336	111	39	111		499	67
68	Flooring	2007	5,495	141	39	141		623	68
69	Construction Interest	2007	254,781	6,533	39	6,533		27,765	69
70	TOTAL (lines 4 thru 69)		$ 3,615,307	$ 93,388		$ 93,388	$	$ 499,228	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,615,307	$ 93,388		$ 93,388	$	$ 499,228	1
2	Walk-in freezer	2007	10,281	1,469	7	1,469		6,121	2
3	Doors, &Fire Alarm	2007	7,577	194	39	194		792	3
4	Floor Tile	2008	2,358	60	39	60		240	4
5	Sprinklers	2008	11,969	307	39	307		1,152	5
6	Floor Tile	2008	8,368	214	39	214		786	6
7	Laminate Flooring	2008	7,562	194	39	194		695	7
8	Tile flooring - foyer	2009	4,261	109	39	109		273	8
9	Parking lot expansion	2009	26,860	689	39	689		1,493	9
10	Dining room floor	2009	9,167	235	39	235		489	10
11	Ductwork and registers for dining room	2009	6,500	166	39	166		346	11
12	Ceiling demo, new drywall and trimwork	2009	8,817	226	39	226		471	12
13	Electrical, lighting, trimwork, and installation	2009	25,639	657	39	657		1,369	13
14	Ceiling tiles	2009	11,256	289	39	289		602	14
15	Parking lot	2010	21,640	555	39	555		1,063	15
16	Water softener	2010	7,876	202	39	202		370	16
17	Dining room, office, recept walls, trimwork	2010	36,998	948	39	948		1,659	17
18	Dining room, office, reception trim, ceiling, floor	2010	49,716	1,275	39	1,275		2,232	18
19	Reception desk, counters	2010	5,759	147	39	147		221	19
20	Reception, office carpeting	2010	11,377	292	39	292		438	20
21									21
22	Electrical raceway, control	2011	8,146	192	39	192		192	22
23	Electrical, lighting	2011	3,820	65	39	65		65	23
24	Front office trimwork	2011	1,750	31	39	31		31	24
25	Parking lot	2011	18,000	232	39	232		232	25
26	Flooring for patient rooms	2011	5,649	61	39	61		61	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,926,653	$ 102,197		$ 102,197	$	$ 520,621	34

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

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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	$ 958,680	$ 118,369	$ 118,369	$		$ 827,810	71
72	Current Year Purchases	35,020	2,574	2,574			2,574	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 993,700	$ 120,943	$ 120,943	$		$ 830,384	75

D. Vehicle Costs. (See instructions.)*

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

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,970,353	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 223,140	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 223,140	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)	$ 1,351,005	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: 01/01/11 Ending: 12/31/11

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: *

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.	/2012	$
13.	/2013	$
14.	/2014	$

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: 01/01/11 Ending: 12/31/11

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.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

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

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.

Facility Name & ID Number East Bank Center LLC

STATE OF ILLINOIS
0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$	43,286	$ 493,416	$	43,286	$ 493,416	1
2	Licensed Speech and Language Development Therapist	39-3	hrs		4,810	54,824		4,810	54,824	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs		48,096	548,240		48,096	548,240	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-3	# of prescrpts				526,321		526,321	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Outpatient Services	39-3					43,259		43,259	12
13	Other (specify): Lab Services	39-3					97,348		97,348	13
14	TOTAL			$	96,192	$ 1,096,480	$ 666,928	96,192	$ 1,763,408	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.

STATE OF ILLINOIS

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/11 (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	$ (162,288)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 121,000)	1,095,713		3
4	Supply Inventory (priced at)	14,629		4
5	Short-Term Investments			5
6	Prepaid Insurance	104,476		6
7	Other Prepaid Expenses	48,329		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,100,859	$	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	3,926,653		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	993,700		16
17	Accumulated Depreciation (book methods)	(1,351,005)		17
18	Deferred Charges	49,036		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): **Goodwill**	244,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,924,069	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,024,928	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,081,922	$	26
27	Officer's Accounts Payable	8,751		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	932,631		29
30	Accrued Salaries Payable	48,926		30
31	Accrued Taxes Payable (excluding real estate taxes)	321,737		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,275		32
33	Accrued Interest Payable	83,315		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,503,557	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,668		39
40	Mortgage Payable	3,599,417		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	**Due to affiliates**	(382,121)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,218,964	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,722,521	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (697,593)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,024,928	$	48

*(See instructions.)

Facility Name & ID Number East Bank Center LLC **#** 0047209 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (716,262)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (716,262)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	18,669	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)**	$ 18,669	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)**	$ (697,593)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,354,882	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,354,882	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)**	$ 6,354,882	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	726,057	31
32	Health Care	1,788,840	32
33	General Administration	1,248,049	33
	B. Capital Expense		
34	Ownership	779,093	34
	C. Ancillary Expense		
35	Special Cost Centers	1,794,174	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)***	$ 6,336,213	40
41	**Income before Income Taxes (line 30 minus line 40)****	18,669	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 18,669	43

* **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: 01/01/11 Ending: 12/31/11

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

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,260	2,260	$ 92,141	$ 40.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,270	15,270	428,668	28.07	3
4	Licensed Practical Nurses	22,313	22,313	584,450	26.19	4
5	CNAs & Orderlies	29,701	29,701	317,856	10.70	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	36,003	17.31	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,871	1,871	26,706	14.27	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,543	15,543	158,644	10.21	15
16	Dishwashers					16
17	Maintenance Workers	21	21	924	44.00	17
18	Housekeepers	13,070	13,070	164,956	12.62	18
19	Laundry					19
20	Administrator	4,160	4,160	179,929	43.25	20
21	Assistant Administrator	1,062	1,062	38,604	36.35	21
22	Other Administrative					22
23	Office Manager	2,192	2,192	27,273	12.44	23
24	Clerical	4,129	4,129	132,164	32.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Marketing	4,257	4,257	145,761	34.24	33
34	TOTAL (lines 1 - 33)	117,929	117,929	$ 2,334,079 *	$ 19.79	34

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

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	450	$ 13,815	1-3	35
36	Medical Director	150	12,000	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)	600	$ 25,815		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 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 LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Renee Woods	Administrator	0	$ 76,929
Edna Atanacio	Asst Administ	0	66,604
James Palazzo	Asst Administ	45.3	75,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 218,533

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Wipfli	Accounting	$ 13,235
Richard Peelo & Assoc	Cost reporting	3,750
Sharon Haugh	Billing	5,000
Hovde & Tufo, PC	Legal	13,000
Q. Heiden	Financing	1,100
Robbins, Salomon Patt	Legal	4,701
Pathway Health Services	Consulting	2,500
Danica TRS	Financial	4,000
Rockford Mercantile Exch	Collections	4,125
Midwest Financial Services	Accounting	5,000
Other / accruals	Misc / Other	6,859
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 63,270

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 63,000
Unemployment Compensation Insurance	22,204
FICA Taxes	199,832
Employee Health Insurance	29,804
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contrib	18,229
Disability Insurance	10,383
Life Insurance	10,131
Other	2,027
TOTAL (agree to Schedule V, line 22, col.8)	$ 355,610

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 48)	
Patient Background Checks 707	4,600
Fingerprinting	2,680
License / Permits	1,635
Marketing / Promotion / Public Relations	187,890
Less: Public Relations Expense	(187,890)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,905

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,688
Gasoline	4,254
Seminar Expense	3,289
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,231

**See instructions.

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

Facility Name & ID Number East Bank Center LLC **#** 0047209 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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. $ **6,144** 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. $ **30,766**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name:

(18) Have all costs which do not relate to the provision of long term care been adjusted out 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.