FOR BHF USE

LL1

2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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

I. IDPH License ID Number: 0047209

Facility Name: East Bank Center LLC

Address: 6131 Park Ridge Road (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: 6/15/2005

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 01/01/2016 to 12/31/2016 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: 01/01/2016 Ending: 12/31/2016

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	19,764	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	19,764	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	24	4,273	7,315	11,612	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24	4,273	7,315	11,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.75%

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 7,315

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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	174,523	1,266	19,103	194,892		194,892		194,892			1
2	Food Purchase		151,261		151,261		151,261		151,261			2
3	Housekeeping	171,374	20,214	8,261	199,849		199,849		199,849			3
4	Laundry		6,483		6,483		6,483		6,483			4
5	Heat and Other Utilities			67,658	67,658		67,658		67,658			5
6	Maintenance			91,852	91,852		91,852		91,852			6
7	Other (specify):*											7
8	TOTAL General Services	345,897	179,224	186,874	711,995		711,995		711,995			8
	B. Health Care and Programs											
9	Medical Director			29,011	29,011		29,011		29,011			9
10	Nursing and Medical Records	1,195,468	129,604	6,454	1,331,526		1,331,526		1,331,526			10
10a	Therapy	842,182			842,182		842,182		842,182			10a
11	Activities	70,162	4,425	2,456	77,043		77,043		77,043			11
12	Social Services			1,945	1,945		1,945		1,945			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,107,812	134,029	39,866	2,281,707		2,281,707		2,281,707			16
	C. General Administration											
17	Administrative	167,469			167,469		167,469		167,469			17
18	Directors Fees											18
19	Professional Services			45,734	45,734		45,734		45,734			19
20	Dues, Fees, Subscriptions & Promotions			22,577	22,577		22,577		22,577			20
21	Clerical & General Office Expenses	298,734	17,879	133,149	449,762		449,762		449,762			21
22	Employee Benefits & Payroll Taxes			396,168	396,168		396,168		396,168			22
23	Inservice Training & Education											23
24	Travel and Seminar			35,790	35,790		35,790		35,790			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			95,623	95,623		95,623		95,623			26
27	Other (specify):* marketing / promo	90,500		438,571	529,071		529,071		529,071			27
28	TOTAL General Administration	556,703	17,879	1,167,612	1,742,194		1,742,194		1,742,194			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,010,412	331,132	1,394,352	4,735,896		4,735,896		4,735,896			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: 01/01/2016 Ending: 12/31/2016

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			115,878	115,878		115,878		115,878			30
31	Amortization of Pre-Op. & Org.			1,218	1,218		1,218		1,218			31
32	Interest			298,744	298,744		298,744		298,744			32
33	Real Estate Taxes			35,590	35,590		35,590		35,590			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			451,430	451,430		451,430		451,430			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			597,387	597,387		597,387		597,387			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**			653,427	653,427		653,427		653,427			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,010,412	331,132	2,499,209	5,840,753		5,840,753		5,840,753			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: 01/01/2016 Ending: 12/31/2016

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,393)			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	(419,426)			24
25	Fund Raising, Advertising and Promotional	(109,649)			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)**	$ (538,468)		$	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))**	$ (538,468)		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	38,661	39	39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology		X	26,314	39	42
43	Prescription Drugs		X	532,412	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)**			$ 653,427		47

East Bank Center LLC

ID# 0047209

Report Period Beginning: 01/01/2016

Ending: 12/31/2016

	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:** 01/01/2016 **Ending:** 12/31/2016

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	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

Summary B

Facility Name & ID Number East Bank Center LLC # 0047209 **Report Period Beginning:** 01/01/2016 **Ending:** 12/31/2016

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Advanced Management Company	66.84			Transitions Hospice	Huntley	Hospice
U. Parekh	31.67			Advantage Medical Eq	Huntley	DME and Supplies
E. Atanacio	1.49			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. ☐ 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	10	DME and Supplies	$ 23,232	Advantage Medical Equipment		$ 23,232	$	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			$ 23,232			$ 23,232	$ *	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: 01/01/2016 Ending: 12/31/2016

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: 01/01/2016 Ending: 12/31/2016

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	Activities/Admiss/Dis	Activities/Admin	0.01	0	40	100.00	wages	$ 70,162	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	$ 70,162		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: 01/01/2016 Ending: 2/31/2016

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: 01/01/2016 Ending: 12/31/2016

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	SL Capital		X	Mortgage	$35,000.00	6/17/05	$ 3,941,429	$ 3,645,449	7/31/17	7.5500	$ 282,493	1
2	Advanced Management Co.	X		Operations	None		159,463	38,011				2
3	S. Parekh	X		Operations	None		70,000	70,000			7,500	3
4	J. Palazzo	X		Operations	None		8,751	8,751				4
5	U. Parekh	X		Term Loan	Interest	1/31/14	250,000	250,000			6,250	5
	Working Capital											
6	U. Parekh	X		Working Capital / LOC	None	11/5/14	250,000	250,000	11/20/17	10.0000	6,250	6
7	U. Parekh & Other ST loans	X		Working Capital	Interest	Var	var	154,375	var	var	(3,749)	7
8												8
9	TOTAL Facility Related				$35,000.00		$ 4,679,643	$ 4,416,586			$ 298,744	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,679,643	$ 4,416,586			$ 298,744	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: 01/01/2016 Ending: 12/31/2016

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 28,232	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.)		$ 31,133	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,901	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 32,689	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.		$ 35,590	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2011	25,423	8
	2012	26,158	9
	2013	26,895	10
	2014	26,888	11
	2015	31,133	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2015	$	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.

2015 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 2015 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 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-01-252-012	Facility & Land	$ 30,176.00	$ 30,176.00
2.	11-01-177-016	Land	$ 957.00	$ 957.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,133.00	$ 31,133.00

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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: 01/01/2016 Ending: 12/31/2016

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 [ ] 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: 01/01/2016 Ending: 12/31/2016

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	$	$ 250,803	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		2,075	10
11	Overhead& Fee			2006	79,134	2029	39	2029		21,135	11
12	General Requirements			2006	86,308	2213	39	2213		23,052	12
13	Demolition			2006	33,784	866	39	866		9,021	13
14	Concrete			2006	14,818	380	39	380		3,958	14
15	Masonary			2006	33,589	861	39	861		8,969	15
16	Carpentry			2006	75,965	1948	39	1948		20,292	16
17	Doors Frames, Hardware			2006	44,426	1139	39	1139		11,865	17
18	Drywall			2006	90,127	2311	39	2311		24,073	18
19	Architectural Design			2006	54,849	1406	39	1406		14,646	19
20	Insulation			2006	1,090	28	39	28		292	20
21	Roofing			2006	13,298	341	39	341		3,552	21
22	Glass & Glazing			2006	14,790	379	39	379		3,948	22
23	Flooring			2006	35,828	919	39	919		9,573	23
24	Painting			2006	9,304	239	39	239		2,489	24
25	Fire Protection			2006	23,275	597	39	597		6,219	25
26	Plumbing			2006	255,033	6541	39	6541		68,127	26
27	HVAC			2006	64,445	1652	39	1652		17,208	27
28	Electric			2006	109,090	2797	39	2797		29,136	28
29	Communications Systems			2006	25,000	641	39	641		6,677	29
30	Extinguishers, railings, lighting			2006	45,374	1163	39	1163		12,115	30
31	water hookup			2006	6,000	154	39	154		1,604	31
32	site work			2006	15,200	390	39	390		4,062	32
33	wall lamps			2006	10,957	281	39	281		2,927	33
34	Painting			2007	1,192	31	39	31		310	34
35	Glass			2007	2,196	56	39	56		559	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: 01/01/2016 Ending: 12/31/2016

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	$	$ 1,209	37
38	Overhead & Fees	2007	79,626	2,042	39	2,042		19,908	38
39	General Requirements	2007	57,076	1,463	39	1,463		14,265	39
40	Demolition	2007	33,088	848	39	848		8,268	40
41	Site work / foundation	2007	33,459	858	39	858		8,365	41
42	Concrete	2007	31,185	800	39	800		7,800	42
43	Masonry	2007	28,416	729	39	729		7,107	43
44	Carpentry	2007	120,204	3,081	39	3,081		29,934	44
45	Joints & Sealers	2007	1,413	36	39	36		351	45
46	Doors, Frames & Hardware	2007	86,147	2,209	39	2,209		21,538	46
47	Drywall	2007	121,143	3,107	39	3,107		30,180	47
48	Special Finishing	2007	50,225	1,288	39	1,288		12,558	48
49	Insulation	2007	1,414	36	39	36		351	49
50	Architectural	2007	14,424	370	39	370		3,607	50
51	Paving	2007	750	19	39	19		185	51
52	Roofing	2007	11,367	291	39	291		2,838	52
53	Glass & Glazing	2007	22,608	580	39	580		5,655	53
54	Flooring	2007	55,767	1,430	39	1,430		13,942	54
55	Wall Coverings	2007	17,900	459	39	459		4,475	55
56	Fire Protection	2007	25,200	646	39	646		6,299	56
57	Plumbing	2007	233,029	5,975	39	5,975		58,145	57
58	HVAC	2007	106,700	2,736	39	2,736		26,676	58
59	Electrical	2007	172,039	4,412	39	4,412		43,011	59
60	Communication Systems	2007	24,857	637	39	637		6,211	60
61	Landscaping	2007	2,920	75	39	75		731	61
62	Signage	2007	5,875		7			5,875	62
63	Floor Tile	2007	4,774	123	39	123		1,176	63
64	Building Pipe	2007	2,463	63	39	63		604	64
65	Building Permit	2007	2,935	75	39	75		720	65
66	2 Doors	2007	1,575	40	39	40		384	66
67	Floor Tile	2007	4,336	111	39	111		1,055	67
68	Flooring	2007	5,495	141	39	141		1,327	68
69	Construction Interest	2007	254,781	6,533	39	6,533		60,429	69
70	TOTAL (lines 4 thru 69)		$ 3,615,307	$ 92,550		$ 92,550	$	$ 963,866	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: 01/01/2016 Ending: 12/31/2016

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	$ 92,550		$ 92,550	$	$ 963,866	1
2	Walk-in freezer	2007	10,281		7			10,281	2
3	Doors, &Fire Alarm	2007	7,577	194	39	194		1,764	3
4	Floor Tile	2008	2,358	60	39	60		544	4
5	Sprinklers	2008	11,969	307	39	307		2,686	5
6	Floor Tile	2008	8,368	215	39	215		1,860	6
7	Laminate Flooring	2008	7,562	193	39	193		1,663	7
8	Tile flooring - foyer	2009	4,261	109	39	109		819	8
9	Parking lot expansion	2009	26,860	689	39	689		4,936	9
10	Dining room floor	2009	9,167	235	39	235		1,665	10
11	Ductwork and registers for dining room	2009	6,500	167	39	167		1,181	11
12	Ceiling demo, new drywall and trimwork	2009	8,817	226	39	226		1,601	12
13	Electrical, lighting, trimwork, and installation	2009	25,639	657	39	657		4,656	13
14	Ceiling tiles	2009	11,256	289	39	289		2,045	14
15	Parking lot	2010	21,640	555	39	555		3,838	15
16	Water softener	2010	7,876	202	39	202		1,380	16
17	Dining room, office, recept walls, trimwork	2010	36,998	948	39	948		6,402	17
18	Dining room, office, reception trim, ceiling, floor	2010	49,716	1,275	39	1,275		8,605	18
19	Reception desk, counters	2010	5,759	148	39	148		961	19
20	Reception, office carpeting	2010	11,377	292	39	292		1,897	20
21									21
22	Electrical raceway, control	2011	8,146	209	39	209		1,236	22
23	Electrical, lighting	2011	3,820	98	39	98		555	23
24	Front office trimwork	2011	1,750	45	39	45		254	24
25	Parking lot	2011	18,000	461	39	461		2,537	25
26	Flooring for patient rooms	2011	5,649	145	39	145		785	26
27									27
28	Front office trimwork	2012	2,127	55	39	55		273	28
29	Therapy Counter	2012	1,015	26	39	26		128	29
30	Therapy Flooring	2012	2,927	75	39	75		356	30
31	Railing & Fence for Stairs	2012	2,403	62	39	62		262	31
32	Water Heaters	2013	12,800	328	39	328		1,203	32
33	Electrical Panel/breaker/run	2013	14,653	376	39	376		1,378	33
34	TOTAL (lines 1 thru 33)		$ 3,962,578	$ 101,191		$ 101,191	$	$ 1,031,617	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: 01/01/2016 Ending: 12/31/2016

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 12B, Carried Forward		$ 3,962,578	$ 101,191		$ 101,191	$	$ 1,031,617	1
2	Dr. Office Trimwork	2014	2,481	64	39	64		186	2
3	Capitalized Interest	2014	2,872	74	39	74		203	3
4	Trees	2014	2,000	51	39	51		132	4
5	Hallway Carpeting	2014	16,000	409	39	409		888	5
6	Boiler	2014	3,780	97	39	97		202	6
7									7
8	Boiler	2015	4,400	113	39	113		188	8
9	Boiler Pump	2015	1,151	30	39	30		42	9
10									10
11	Roofing	2016	13,975	209	39	209		209	11
12	Roofing	2016	3,361	50	39	50		50	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)		$ 4,012,598	$ 102,288		$ 102,288	$	$ 1,033,717	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: 01/01/2016 Ending: 12/31/2016

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	$ 1,013,838	$ 11,972	$ 11,972	$		$ 996,897	71
72	Current Year Purchases	27,632	1,618	1,618			1,618	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,041,470	$ 13,590	$ 13,590	$		$ 998,515	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)	$ 5,104,068	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 115,878	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 115,878	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)	$ 2,032,232	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: 01/01/2016 Ending: 12/31/2016

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.	/2017	$
13.	/2018	$
14.	/2019	$

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: 01/01/2016 Ending: 12/31/2016

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.

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

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10-a1	9933 hrs	$ 378,982		$	$	9,933	$ 378,982	1
2	Licensed Speech and Language Development Therapist	10-a1	1104 hrs	42,109				1,104	42,109	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10-a1	11037 hrs	421,091				11,037	421,091	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				532,412		532,412	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Outpatient Services	39-3					38,661		38,661	12
13	Other (specify): Lab Services	39-3					26,314		26,314	13
14	TOTAL			$ 842,182		$	$ 597,387	22,074	$ 1,439,569	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 # 0047209 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2016 (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	$ (46,337)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 140,000)	913,081		3
4	Supply Inventory (priced at)	16,408		4
5	Short-Term Investments			5
6	Prepaid Insurance	19,644		6
7	Other Prepaid Expenses	6,476		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 909,272	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	4,012,598		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,041,470		16
17	Accumulated Depreciation (book methods)	(2,032,232)		17
18	Deferred Charges	13,088		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)**	$ 3,340,609	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,249,881	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 792,423	$	26
27	Officer's Accounts Payable	8,751		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	404,375		29
30	Accrued Salaries Payable	156,810		30
31	Accrued Taxes Payable (excluding real estate taxes)	491,310		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,689		32
33	Accrued Interest Payable	183,083		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	51,283		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,120,724	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	358,011		39
40	Mortgage Payable	3,645,449		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)**	$ 4,003,460	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,124,184	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,874,303)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,249,881	$	48

***(See instructions.)**

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,856,965)	1
2	Restatements (describe):		2
3	**Miscellaneous prior year adjustment**	(776)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,857,741)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	91,588	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	(108,150)	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)**	$ (16,562)	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)**	$ (1,874,303)	24 *

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

Facility Name & ID Number East Bank Center LLC # 0047209 Report Period Beginning: 01/01/2016 Ending: 12/31/2016

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,932,341	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,932,341	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)**	$ 5,932,341	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	711,995	31
32	Health Care	2,281,707	32
33	General Administration	1,742,194	33
	B. Capital Expense		
34	Ownership	451,430	34
	C. Ancillary Expense		
35	Special Cost Centers	597,387	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)***	$ 5,840,753	40
41	**Income before Income Taxes (line 30 minus line 40)****	91,588	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 91,588	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 10,609	44
45	Private Pay - Net Inpatient Revenue	144,141	45
46	Medicare - Net Inpatient Revenue	3,969,267	46
47	Other-(specify) Commercial Insurance Revenue	1,807,828	47
48	Other-(specify) Miscellaneous Revenue	496	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 5,932,341	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.

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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	2,200	2,200	$ 96,745	$ 43.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,699	9,699	274,543	28.31	3
4	Licensed Practical Nurses	16,686	16,686	453,996	27.21	4
5	CNAs & Orderlies	31,942	31,942	370,184	11.59	5
6	CNA Trainees					6
7	Licensed Therapist	22,999	22,999	842,182	36.62	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	70,162	33.73	9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	780	780	19,566	25.08	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,915	12,915	154,957	12.00	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	12,924	12,924	171,374	13.26	18
19	Laundry					19
20	Administrator	2,600	2,600	167,469	64.41	20
21	Assistant Administrator					21
22	Other Administrative	4,665	4,665	144,496	30.97	22
23	Office Manager	2,080	2,080	34,380	16.53	23
24	Clerical	2,978	2,978	119,858	40.25	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	2,168	2,168	90,500	41.74	33
34	TOTAL (lines 1 - 33)	126,716	126,716	$ 3,010,412 *	$ 23.76	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	370	$ 19,103	1-3	35
36	Medical Director	267	29,011	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	41	1,945	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	678	$ 50,059		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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lynn Erickson	Administrator	0	$ 105,582
Patrick Scales	Administrator	0	61,887
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 167,469

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
Hovde & Tufo	Legal	$ 13,000
Wipfli CPA's	Accounting	3,330
R. Peelo & Assoc.	Cost Reporting	3,750
S. Haugh	Billing	3,000
Mankus & Marchan LLP	Accounting	12,821
Rockford Mercantile Exchange	Collections	439
Other	Other	9,394
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 45,734

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,100
Unemployment Compensation Insurance	26,057
FICA Taxes	234,517
Employee Health Insurance	27,314
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Contributions	537
Disability Insurance	30,375
Miscellaneous	2,268
TOTAL (agree to Schedule V, line 22, col.8)	$ 396,168

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	$ 3,980
Advertising: Employee Recruitment	0
Health Care Worker Background Check	0
(Indicate # of checks performed 77)	
Patient Background Checks 502	1,607
Fingerprinting	4,330
Marketing/Promotion/Public Relations	109,649
Licenses / Permits	12,660
Less: Public Relations Expense	(109,649)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,577

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	29,369
Gasoline	2,741
Seminar Expense	3,680
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 35,790

**See instructions.

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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.

(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. $ **4,399** 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