		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.

2010
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2010)

I. IDPH License ID Number: 0047332

Facility Name: Rainbow Beach Care Center

Address: 7325 South Exchange Street (Number) Chicago (City) 60649 (Zip Code)

County: Cook

Telephone Number: (773)731-7300 **Fax #** (773)731-5781

HFS ID Number:

Date of Initial License for Current Owners: 08/01/2005

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: Steve Lavenda **Telephone Number:** (847) 236-1111
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 01/01/10 to 12/31/10 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)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Andrew B. Cutler
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	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		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	211	Intermediate (ICF)	211	77,015	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	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					8
9	SNF/PED					9
10	ICF	60,759			60,759	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,759			60,759	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 78.89%

D. How many bed-hold days during this year were paid by the Department?
3,727 (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 08/01/05

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/05 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified ____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

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

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	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	301,170	29,963	22,743	353,876		353,876	4,821	358,697			1
2	Food Purchase		276,223		276,223		276,223	440	276,663			2
3	Housekeeping	203,575	83,462	80,784	367,821		367,821	(2,468)	365,353			3
4	Laundry		292	158,671	158,963		158,963	(26)	158,937			4
5	Heat and Other Utilities			185,939	185,939		185,939	(740)	185,199			5
6	Maintenance	460,658		207,521	668,179		668,179	5,559	673,738			6
7	Other (specify):*							1,975	1,975			7
8	TOTAL General Services	965,403	389,940	655,658	2,011,001		2,011,001	9,561	2,020,562			8
	B. Health Care and Programs											
9	Medical Director			25,200	25,200		25,200		25,200			9
10	Nursing and Medical Records	1,994,718	53,201	97,011	2,144,930		2,144,930	26,929	2,171,859			10
10a	Therapy							4,345	4,345			10a
11	Activities	199,125	14,537		213,662		213,662		213,662			11
12	Social Services	627,213	35,742	9,989	672,944		672,944	3,109	676,053			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*							6,297	6,297			15
16	TOTAL Health Care and Programs	2,821,056	103,480	132,200	3,056,736		3,056,736	40,680	3,097,416			16
	C. General Administration											
17	Administrative	163,040		25,000	188,040		188,040	55,758	243,798			17
18	Directors Fees											18
19	Professional Services			394,324	394,324	(29,760)	364,564	(286,642)	77,922			19
20	Dues, Fees, Subscriptions & Promotions			29,258	29,258		29,258	845	30,103			20
21	Clerical & General Office Expenses	142,882	23,083	212,320	378,285		378,285	(18,643)	359,642			21
22	Employee Benefits & Payroll Taxes			804,986	804,986		804,986	(3,296)	801,690			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,747	6,747		6,747	1,650	8,397			24
25	Other Admin. Staff Transportation			21,235	21,235		21,235	(9,020)	12,215			25
26	Insurance-Prop.Liab.Malpractice			128,871	128,871		128,871	1,033	129,904			26
27	Other (specify):*							29,128	29,128			27
28	TOTAL General Administration	305,922	23,083	1,622,741	1,951,746	(29,760)	1,921,986	(229,188)	1,692,798			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,092,381	516,503	2,410,599	7,019,483	(29,760)	6,989,723	(178,946)	6,810,777			29

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

SEE ACCOUNTANTS' COMPILATION REPORT

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 Rainbow Beach Care Center #0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			128,932	128,932		128,932	216,261	345,193			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			44,770	44,770		44,770	1,276,642	1,321,412			32
33	Real Estate Taxes			(35,068)	(35,068)	29,760	(5,308)	267,654	262,346			33
34	Rent-Facility & Grounds			2,010,000	2,010,000		2,010,000	(2,008,732)	1,268			34
35	Rent-Equipment & Vehicles			23,646	23,646		23,646	(8,188)	15,458			35
36	Other (specify):*							254,203	254,203			36
37	**TOTAL Ownership**			2,172,280	2,172,280	29,760	2,202,040	(2,160)	2,199,880			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,760		2,760		2,760	(1,483)	1,277			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			115,523	115,523		115,523		115,523			42
43	Other (specify):*	252,882			252,882		252,882	(252,882)	(0)			43
44	**TOTAL Special Cost Centers**	252,882	2,760	115,523	371,165		371,165	(254,365)	116,800			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,345,263	519,263	4,698,402	9,562,928		9,562,928	(435,472)	9,127,456			45

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	(2,154)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(209,165)	30		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		02		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	(18,230)	21		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	(141,830)	21		24
25	Fund Raising, Advertising and Promotional	(2,247)	20		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	(284,538)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (658,165)		$	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)	222,693		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 222,693		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (435,472)		37

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

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Rainbow Beach Care Center

ID# 0047332

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Jury Duty Income	$ (143)	21	1
2	Patient Clothing	(452)	10	2
3	Theft Loss	(396)	21	3
4	Collections Expense	(408)	21	4
5	Building Company - Filing Fee	(250)	21	5
6	Secretary of State - Annual Report	(250)	20	6
7	Building Company - Amortization	(7,976)	36	7
8	Secretary of State - Articles of Ammendment	(150)	20	8
9	Non-Allowable Legal	(1,746)	19	9
10	Insurance Refund	(17)	26	10
11	Non-Allowable Travel	(9,823)	25	11
12	Miscellaneous Income	(62)	21	12
13	Non-Allowable Salary	(200,000)	43	13
14	Prior Period Office Expense	(3,880)	21	14
15	Capitalized R&M	(6,102)	06	15
16	Marketing Salary	(52,882)	43	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**	(284,538)		49

Rainbow Beach Care Center

ID# 0047332

Report Period Beginning: 01/01/10

Ending: 12/31/10

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98				49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			158		4,669		(6)					4,821	1
2	Food Purchase			440									440	2
3	Housekeeping			565		62		(3,095)					(2,468)	3
4	Laundry							(26)					(26)	4
5	Heat and Other Utilities	(2,154)		1,283		131							(740)	5
6	Maintenance	(6,102)		3,686	7,907	130		(62)					5,559	6
7	Other (specify):*				1,321	654							1,975	7
8	**TOTAL General Services**	(8,256)		6,132	9,228	5,646		(3,189)					9,561	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(452)				30,047		(2,666)					26,929	10
10a	Therapy					4,345							4,345	10a
11	Activities													11
12	Social Services					3,109							3,109	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					5,256	1,041						6,297	15
16	**TOTAL Health Care and Programs**	(452)				42,757	1,041	(2,666)					40,680	16
	C. General Administration													
17	Administrative			2,612	10,143	43,003							55,758	17
18	Directors Fees													18
19	Professional Services	(1,746)		(175,716)		(109,180)							(286,642)	19
20	Fees, Subscriptions & Promotions	(2,647)		3,311		186		(5)					845	20
21	Clerical & General Office Expenses	(165,199)	250	15,472	122,937	7,897							(18,643)	21
22	Employee Benefits & Payroll Taxes				(2,262)		(1,041)	7					(3,296)	22
23	Inservice Training & Education													23
24	Travel and Seminar			162		1,488							1,650	24
25	Other Admin. Staff Transportation	(9,823)		803									(9,020)	25
26	Insurance-Prop.Liab.Malpractice	(17)		881		169							1,033	26
27	Other (specify):*				22,238	6,890							29,128	27
28	**TOTAL General Administration**	(179,433)	250	(152,475)	153,056	(49,547)	(1,041)	2					(229,188)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(188,141)	250	(146,343)	162,284	(1,144)		(5,853)					(178,946)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Rainbow Beach Care Center** **#** **0047332** **Report Period Beginning:** **01/01/10** **Ending:** **12/31/10**

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

	Capital Expense 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	(209,165)	419,765	4,761		900							216,261	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		1,250,393	9,087		17,162							1,276,642	32
33	Real Estate Taxes		265,606	1,845		203							267,654	33
34	Rent-Facility & Grounds		(2,010,000)	1,268									(2,008,732)	34
35	Rent-Equipment & Vehicles			2,273						(10,461)			(8,188)	35
36	Other (specify):*	(7,976)	262,179										254,203	36
37	**TOTAL Ownership**	(217,141)	187,943	19,234		18,265				(10,461)			(2,160)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers									(1,483)			(1,483)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(252,882)											(252,882)	43
44	**TOTAL Special Cost Centers**	(252,882)								(1,483)			(254,365)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(658,165)	188,193	(127,109)	162,284	17,121		(5,853)		(11,944)			(435,472)	45

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Rainbow Beach Real Estate		Building Company

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	34	Rent	$ 2,010,000	Rainbow Beach Real Estate		$	$ (2,010,000)	1
2	V	32	Interest	376	Rainbow Beach Real Estate		1,250,769	1,250,393	2
3	V	33	Real Estate Taxes	(35,068)	Rainbow Beach Real Estate		230,538	265,606	3
4	V	21	Filing Fee		Rainbow Beach Real Estate		250	250	4
5	V	30	Depreciaiton Expense		Rainbow Beach Real Estate		419,765	419,765	5
6	V	36	Amortization Expense		Rainbow Beach Real Estate		7,976	7,976	6
7	V	36	Mortgage Insurance Premium		Rainbow Beach Real Estate		254,203	254,203	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,975,308			$ 2,163,501	$ * 188,193	14

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	01	Dietary	$	Extended Care Consulting, LLC	100.00%	$ 158	$ 158	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	440	440	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	565	565	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,283	1,283	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,686	3,686	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	2,612	2,612	20
21	V	19	Professional Fees	186,604	Extended Care Consulting, LLC	100.00%	10,888	(175,716)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,311	3,311	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	15,472	15,472	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	162	162	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	803	803	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	881	881	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	4,761	4,761	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	9,087	9,087	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,845	1,845	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%	1,268	1,268	30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	2,273	2,273	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 186,604			$ 59,495	$ * (127,109)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	7,907	$ 7,907	15
16	V	06	Maintenance (Direct)	402	Extended Care Consulting, LLC	100.00%	402		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,321	1,321	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V	12	Admission (Direct)		Extended Care Consulting, LLC	100.00%			19
20	V	15	Emp. Ben. - Nursing (Direct)		Extended Care Consulting, LLC	100.00%			20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	10,143	10,143	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	122,937	122,937	22
23	V	21	Office and Clerical (Direct)		Extended Care Consulting, LLC	100.00%			23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	22,238	22,238	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%			25
26	V	22	Employee Benefits	2,262	Extended Care Consulting, LLC	100.00%		(2,262)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,664			$ 164,948	$ * 162,284	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	03	Housekeeping	$	Extended Care Clinical, LLC	100.00%	$ 62	$ 62	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	131	131	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	130	130	17
18	V	19	Professional Fees	116,477	Extended Care Clinical, LLC	100.00%	7,297	(109,180)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	186	186	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	1,742	1,742	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	1,488	1,488	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	169	169	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	900	900	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	17,162	17,162	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	203	203	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	4,669	4,669	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	654	654	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	30,047	30,047	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%	4,345	4,345	29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	3,109	3,109	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	5,256	5,256	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	43,003	43,003	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	6,155	6,155	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	6,890	6,890	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 116,477			$ 133,598	$ * 17,121	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	01	Dietary Salary	$	Extended Care Clinical, LLC	100.00%	$	$	15
16	V	07	Emp. Ben. - General		Extended Care Clinical, LLC	100.00%			16
17	V	10	Nursing Salary	9,837	Extended Care Clinical, LLC	100.00%	9,837		17
18	V	12	Social Service Salary	1,076	Extended Care Clinical, LLC	100.00%	1,076		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	1,041	1,041	19
20	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%			20
21	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%			21
22	V	22	Employee Benefits	1,041	Extended Care Clinical, LLC	100.00%		(1,041)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 11,954			$ 11,954	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	1	Dietary	$ 89	Xcel Supply, LLC	100.00%	$ 83	$ (6)	15
16	V	3	Housekeeping	46,446	Xcel Supply, LLC	100.00%	43,351	(3,095)	16
17	V	4	Laundry	383	Xcel Supply, LLC	100.00%	358	(26)	17
18	V	6	Repairs & Maintenance	931	Xcel Supply, LLC	100.00%	869	(62)	18
19	V	10	Nursing	40,001	Xcel Supply, LLC	100.00%	37,336	(2,666)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	12	Social Service		Xcel Supply, LLC	100.00%			21
22	V	20	Dues, Fees And Subscriptions	82	Xcel Supply, LLC	100.00%	76	(5)	22
23	V	21	Office And Clerical		Xcel Supply, LLC	100.00%			23
24	V	22	Employee Benefits	(107)	Xcel Supply, LLC	100.00%	(100)	7	24
25	V	24	Seminars & Education		Xcel Supply, LLC	100.00%			25
26	V	39	Ancillary		Xcel Supply, LLC	100.00%			26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 87,825			$ 81,972	$ * (5,853)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	22	Employee Health Insurance	$	CCS Employee Benefits Group	100.00%	$ 72,976	$ 72,976	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	72,976	CCS Employee Benefits Group	100.00%		(72,976)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,976			$ 72,976	$ *	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [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)	
15	V	35	Matrix Leasing	$ 19,465	Vent Lease LLC	100.00%	$ 9,004	$ (10,461)	15
16	V	39	Ventilator Equipment	2,760	Vent Lease LLC	100.00%	1,277	(1,483)	16
17	V	39	Other Ancillary		Vent Lease LLC	100.00%			17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 22,225			$ 10,281	$ * (11,944)	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] 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)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VII. RELATED PARTIES (continued)

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

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

	1	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	Eric Rothner	Shareholder	Administrative	51.00%	See Attached	1.51	3.25%		$		1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	2.21	4.02%	Al Sal/Al Fees	6,423	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	0.38	0.95%	Alloc. Salary	670	22-7	3
4	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.15	0.67%	Alloc. Salary	522	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,615		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 Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary	Patient Days	1,512,273	34	$ 3,931	$	60,759	$ 158	1
2	02	Food	Patient Days	1,512,273	34	10,940		60,759	440	2
3	03	Housekeeping	Patient Days	1,512,273	34	14,059		60,759	565	3
4	05	Utilities	Patient Days	1,512,273	34	31,923		60,759	1,283	4
5	06	Maintenance	Patient Days	1,512,273	34	91,744		60,759	3,686	5
6	17	Administrative	Patient Days	1,512,273	34	65,000		60,759	2,612	6
7	19	Professional Fees	Patient Days	1,512,273	34	271,007		60,759	10,888	7
8	20	Dues and Subscriptions	Patient Days	1,512,273	34	82,419		60,759	3,311	8
9	21	Office and Clerical	Patient Days	1,512,273	34	385,083		60,759	15,472	9
10	24	Seminar and Travel	Patient Days	1,512,273	34	4,022		60,759	162	10
11	25	Other Staff Admin. Trans.	Patient Days	1,512,273	34	19,982		60,759	803	11
12	26	Insurance	Patient Days	1,512,273	34	21,934		60,759	881	12
13	30	Depreciation	Patient Days	1,512,273	34	118,510		60,759	4,761	13
14	32	Interest	Patient Days	1,512,273	34	226,162		60,759	9,087	14
15	33	Real Estate Taxes	Patient Days	1,512,273	34	45,910		60,759	1,845	15
16	34	Rent - Building	Patient Days	1,512,273	34	31,555		60,759	1,268	16
17	35	Rent - Equipment & Auto	Patient Days	1,512,273	34	56,569		60,759	2,273	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,480,749	$		$ 59,495	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Extended Care Consulting, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	06	Maintenance (Pooled)	Patient Days	1,512,273	34	196,794	196,794	60,759	7,907	1
2	06	Maintenance (Direct)	Direct		34	32,478	32,478		402	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,512,273	34	32,885		60,759	1,321	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		34	3,607				4
5	12	Admission (Direct)	Direct		34	52,036	52,036			5
6	15	Emp. Ben. - Nursing (Direct)	Direct		34	5,270				6
7	17	Administrative (Pooled)	Patient Days	1,512,273	34	252,448	252,448	60,759	10,143	7
8	21	Office and Clerical (Pooled)	Patient Days	1,512,273	34	3,059,876	3,059,876	60,759	122,937	8
9	21	Office and Clerical (Direct)	Direct		34	771,063	771,063			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,512,273	34	553,505		60,759	22,238	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		34	94,865				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					$ 5,054,827	$ 4,364,695		$ 164,948	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	03	Housekeeping	Patient Days	1,512,273	34	$ 1,549	$	60,759	$ 62	1
2	05	Utilities	Patient Days	1,512,273	34	3,268		60,759	131	2
3	06	Maintenance	Patient Days	1,512,273	34	3,240		60,759	130	3
4	19	Professional Fees	Patient Days	1,512,273	34	181,624		60,759	7,297	4
5	20	Dues and Subscriptions	Patient Days	1,512,273	34	4,624		60,759	186	5
6	21	Office & Clerical	Patient Days	1,512,273	34	43,370		60,759	1,742	6
7	24	Travel and Seminar	Patient Days	1,512,273	34	37,025		60,759	1,488	7
8	26	Insurance	Patient Days	1,512,273	34	4,213		60,759	169	8
9	30	Depreciation	Patient Days	1,512,273	34	22,389		60,759	900	9
10	32	Interest	Patient Days	1,512,273	34	427,165		60,759	17,162	10
11	33	Real Estate Taxes	Patient Days	1,512,273	34	5,058		60,759	203	11
12	01	Dietary Salary	Patient Days	1,512,273	34	116,221	116,221	60,759	4,669	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	1,512,273	34	16,288		60,759	654	13
14	10	Nursing Salary	Patient Days	1,512,273	34	747,870	747,870	60,759	30,047	14
15	10a	Rehab Salary	Patient Days	1,512,273	34	108,151	108,151	60,759	4,345	15
16	12	Social Service Salary	Patient Days	1,512,273	34	77,377	77,377	60,759	3,109	16
17	15	Emp. Ben. - Healthcare	Patient Days	1,512,273	34	130,816		60,759	5,256	17
18	17	Administration Salary	Patient Days	1,512,273	34	1,070,339	1,070,339	60,759	43,003	18
19	21	Office Salary	Patient Days	1,512,273	34	153,206	153,206	60,759	6,155	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	1,512,273	34	171,480		60,759	6,890	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,325,274	$ 2,273,164		$ 133,598	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Extended Care Clinical, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	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	01	Dietary Salary	Direct Allocation			$ 15,960	$ 15,960		$	1
2	07	Emp. Ben. - General	Direct Allocation			1,662				2
3	10	Nursing Salary	Direct Allocation			495,330	495,330		9,837	3
4	12	Social Service Salary	Direct Allocation			274,597	274,597		1,076	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			94,697			1,041	5
6	17	Administration Salary	Direct Allocation			82,389	82,389			6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation			10,053				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					$ 974,688	$ 868,276		$ 11,954	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

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

Name of Related Organization: Xcel Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	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	Dietary	Direct Allocation			$	$		$ 83	1
2	3	Housekeeping	Direct Allocation						43,351	2
3	4	Laundry	Direct Allocation						358	3
4	6	Repairs & Maintenance	Direct Allocation						869	4
5	10	Nursing	Direct Allocation						37,336	5
6	11	Activities	Direct Allocation							6
7	12	Social Service	Direct Allocation							7
8	20	Dues, Fees And Subscriptions	Direct Allocation						76	8
9	21	Office And Clerical	Direct Allocation							9
10	22	Employee Benefits	Direct Allocation						(100)	10
11	24	Seminars & Education	Direct Allocation							11
12	39	Ancillary	Direct Allocation							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					$	$		$ 81,972	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES X NO

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

Name of Related Organization: CCS Employee Benefits Group, Inc.
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	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	22	Employee Health Insurance	Direct Allocation			$	$		$ 72,976	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					$	$		$ 72,976	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES X NO

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

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 W. Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	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	35	Matrix Leasing	Direct Allocation			$	$		$ 9,004	1
2	39	Ventilator Equipment	Direct Allocation						1,277	2
3	39	Other Ancillary	Direct Allocation							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					$	$		$ 10,281	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 26,191,564			$ 1,250,769	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Private Bank		X	Line of Credit							29,606	6
7	VGM Financial		X	Note Payable							1,754	7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 26,191,564			$ 1,282,129	9
	B. Non-Facility Related*											
10	Dowd, Block & Bennett		X	Welfare & Pension Funds							13,410	10
11	Building Co. Interest Income		X								(376)	11
12												12
13	See Supplemental Schedule										26,249	13
14	TOTAL Non-Facility Related						$	$			$ 39,283	14
15	TOTALS (line 9+line14)						$	$ 26,191,564			$ 1,321,412	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 254,203 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

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** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16	EC Consulting Allocation	X									9,087	16
17	EC Clinical Allocation	X									17,162	17
18												18
19												19
20	TOTAL Non-Facility Related										26,249	20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** 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 Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

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

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2009 report.	$ 216,991	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.)	$ 220,355	2
3. Under or (over) accrual (line 2 minus line 1).	$ 3,364	3
4. Real Estate Tax accrual used for 2010 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 229,222	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.**	$ 29,760	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** $ 4,914 **For** 2007 **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.	$ 262,346	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2005	188,321	8
2006	206,813	9
2007	204,605	10
2008	206,658	11
2009	218,307	12

2010 Accrual: $218,327 x 1.05 = $229,222 (Rounded)
Allocated from Extended Care Consulting: $1,845
Allocated from Extended Care Clinical: $203

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2009	$	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.

2009 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rainbow Beach Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047332

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-112-004-0000	Long Term Care Property	$ 1,260.58	$ 1,260.58
2.	21-30-112-007-0000	Long Term Care Property	$ 32,643.35	$ 32,643.35
3.	21-30-112-008-0000	Long Term Care Property	$ 36,696.09	$ 36,696.09
4.	21-30-112-011-0000	Long Term Care Property	$ 261.19	$ 261.19
5.	21-30-112-012-0000	Long Term Care Property	$ 261.19	$ 261.19
6.	21-30-112-013-0000	Long Term Care Property	$ 30,906.83	$ 30,906.83
7.	21-30-112-014-0000	Long Term Care Property	$ 39,136.74	$ 39,136.74
8.	21-30-112-017-0000	Long Term Care Property	$ 786.36	$ 786.36
9.	21-30-112-018-0000	Long Term Care Property	$ 791.36	$ 791.36
10.	21-30-112-051-0000	Long Term Care Property	$ 69,523.08	$ 69,523.08
		TOTALS	$ 212,266.77	$ 212,266.77

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? X YES _____ NO

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

C. **Tax Bills**

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

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2008 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rainbow Beach Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047332

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2009 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2009.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-112-052-0000	Long Term Care Property	$ 6,040.27	$ 6,040.27
2.	See Attached	2201 Main Allocation	$ 116,500.56	$ 2,094.90
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 122,540.83	$ 8,135.17

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? X YES _____ NO

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

C. **Tax Bills**

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

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,645 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

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

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [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	Facility			$ 485,009	1
2	Allocated from EC Consulting 2201/Clinical 2201			14,745	2
3	TOTALS			$ 499,754	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	39,668		20	1,983	1,983	10,248	9
10	Various			2006	338,166		20	29,284	29,284	134,900	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

*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 Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		9,549,265	297,030		244,853	(52,177)	1,469,118	67
68	Related Party Allocations (Pages 12H & 12I)		59,426	4,044		4,044		28,323	68
69	Financial Statement Depreciation			75,701			(75,701)		69
70	TOTAL (lines 4 thru 69)		$ 9,986,525	$ 376,775		$ 280,165	$ (96,610)	$ 1,642,588	70

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 9,986,525	$ 376,775		$ 280,165	$ (96,610)	$ 1,642,588	1
2	Foundation Work - Repair On Drainage System	2007	31,230		20	1,562	1,562	6,116	2
3	Remodel - Shower Stalls	2007	32,400		20	1,620	1,620	5,670	3
4	Repair - Laundry Rm Leakage	2007	11,700		20	585	585	2,048	4
5	Catch Basin & Asphalt Repair	2007	2,782		20	139	139	475	5
6	Installation Of Fire Damper Actuators	2007	12,362		20	1,236	1,236	3,915	6
7	New Boiler	2007	10,763		20	897	897	2,840	7
8	New Fire Alarm System	2007	29,789		20	4,256	4,256	13,476	8
9	Door Replacement	2008	5,785		20	289	289	868	9
10	Expansion Tank	2008	4,311		20	216	216	647	10
11	Replacing Boards And Parts On Elevator	2008	3,770		20	189	189	550	11
12	Replaced Parts For Elevator Due To Water Damage	2008	6,010		20	301	301	876	12
13	Adj #54 - Proceeds From Insurance	2008	(2,234)		20	(112)	(112)	(326)	13
14	Doors	2008	6,145		20	307	307	871	14
15	Steel Doors	2008	5,220		20	261	261	696	15
16	Water Heater	2008	11,588		20	2,318	2,318	6,180	16
17	Installation Of New Washer & Dryer	2008	2,000		20	400	400	1,033	17
18	Work On Elevator Shaft	2008	28,480		20	1,424	1,424	3,679	18
19	Elevator Installation	2008	111,525		20	5,576	5,576	14,405	19
20	New Laundry Rooms	2008	12,150		20	608	608	1,519	20
21	Elevator Repair	2008	15,000		20	750	750	1,813	21
22	Roof Repairs	2008	4,600		20	230	230	518	22
23	Replaced 2 Rooftop Hvac Units	2008	15,985		20	799	799	1,798	23
24	Elevator Pit Repairs	2008	20,000		20	1,000	1,000	2,167	24
25	Elevator Shaft Repair	2009	28,000		20	1,400	1,400	2,100	25
26	Elevator Door Repair	2009	3,120		20	156	156	234	26
27	Replace Relief Valves On Trane Chiller	2009	4,828		20	966	966	1,448	27
28	Elevator Shaft Repair	2009	20,000		20	1,000	1,000	2,000	28
29	Hot Water Coil	2009	4,487		20	897	897	1,795	29
30	Elevator Fire Alarm	2009	7,735		20	387	387	645	30
31	Replace Train Hot Water Coil	2009	3,877		20	775	775	1,034	31
32	Installation Of 2 Metal Doors	2009	8,500		20	425	425	602	32
33	Elevator Shaft Repair	2009	25,000		20	1,250	1,250	2,396	33
34	TOTAL (lines 1 thru 33)		$ 10,473,433	$ 376,775		$ 312,270	$ (64,505)	$ 1,726,674	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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		$ 10,473,433	$ 376,775		$ 312,270	$ (64,505)	$ 1,726,674	1
2	Cubicle Curtain	2009	6,807		20	681	681	1,305	2
3	Elevator Shaft	2009	(14,240)		20	(1,424)	(1,424)	(1,543)	3
4	Valves And Gaskets	2010	3,186		20	106	106	106	4
5	Door And Frame	2010	3,100		20	90	90	90	5
6	Metal Door And Frame	2010	7,985		20	233	233	233	6
7	Fire Dampers	2010	3,330		20	55	55	55	7
8	Stairwell Locks	2010	4,475		20	56	56	56	8
9	Generator Repairs	2010	2,772		20	139	139	139	9
10	Fire Dampers	2010	3,330		20	166	166	166	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,494,177	$ 376,775		$ 312,373	$ (64,402)	$ 1,727,282	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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 12C, Carried Forward		$ 10,494,177	$ 376,775		$ 312,373	$ (64,402)	$ 1,727,282	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	TOTAL (lines 1 thru 33)		$ 10,494,177	$ 376,775		$ 312,373	$ (64,402)	$ 1,727,282	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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 12D, Carried Forward		$ 10,494,177	$ 376,775		$ 312,373	$ (64,402)	$ 1,727,282	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
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17									17
18									18
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20									20
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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)		$ 10,494,177	$ 376,775		$ 312,373	$ (64,402)	$ 1,727,282	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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	Building Company Information								1
2	Buildings:								2
3		1960	9,549,265	297,030	39	244,853	(52,177)	1,469,118	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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	Building Company Information Continued		$	$		$	$	$	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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12F & 12G lines 1 thru 33)		$ 9,549,265	$ 297,030		$ 244,853	$ (52,177)	$ 1,469,118	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main, LLC	2002	18,303	469	39	469		3,891	3
4	Allocated from Extended Care Clinical 2201 Main, LLC	2002	2,016	52	39	52		429	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	185	9	20	9		37	9
10	Allocated from Extended Care Consulting, LLC	2009	110	6	20	6		11	10
11	Allocated from Extended Care Consulting, LLC	2010	1,084	54	20	54		54	11
12									12
13	Allocated from Extended Care Consulting 2201 Main, LLC	2002	15,120	1,382	20	1,382		9,686	13
14	Allocated from Extended Care Consulting 2201 Main, LLC	2003	17,818	1,628	20	1,628		11,414	14
15	Allocated from Extended Care Consulting 2201 Main, LLC	2005	885	94	20	94		413	15
16	Allocated from Extended Care Consulting 2201 Main, LLC	2009	160	8	20	8		16	16
17									17
18	Allocated from Extended Care Clinical 2201 Main, LLC	2002	1,666	152	20	152		1,067	18
19	Allocated from Extended Care Clinical 2201 Main, LLC	2003	1,963	179	20	179		1,257	19
20	Allocated from Extended Care Clinical 2201 Main, LLC	2005	98	10	20	10		46	20
21	Allocated from Extended Care Clinical 2201 Main, LLC	2009	18	1	20	1		2	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

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

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

	1 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	Related Party Information Continued								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
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 59,426	$ 4,044		$ 4,044	$	$ 28,323	34

SEE ACCOUNTANTS' COMPILATION REPORT

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 173,239	$ 53,382	$ 31,355	$ (22,027)	10	$ 115,655	71
72	Current Year Purchases	10,440	2,993	814	(2,179)	10	814	72
73	Fully Depreciated Assets	117,123	120,557		(120,557)	10	117,123	73
74								74
75	TOTALS	$ 300,802	$ 176,932	$ 32,169	$ (144,763)		$ 233,592	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Cc	2010	$ 1,009	$ 202	$ 202	$	5	$ 605	76
77		Allocated from Extended Care Cc	2010	11,911				5	11,911	77
78		Allocated from Extended Care Cl	2010	2,246	449	449		5	1,048	78
79										79
80	TOTALS			$ 15,166	$ 651	$ 651	$		$ 13,564	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)	$ 11,309,899	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 554,358	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 345,193	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (209,165)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,974,438	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 Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
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	Allocated from Extended Care Consulting				1,268			5
6								6
7	TOTAL				$ 1,268 **			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.	/2011	$
13.	/2012	$
14.	/2013	$

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: $ 15,355 Description: See Attached Schedule
(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	Administrative		$	$ 103	17
18					18
19					19
20					20
21	TOTAL		$	$ 103	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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

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.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

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		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental						2,760		2,760	13
14	TOTAL			$		$	$ 2,760		$ 2,760	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.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/10 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 514,723	$ 585,917	1
2	Cash-Patient Deposits	41,167	41,167	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	190,830	190,830	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	162,606	281,987	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		1,032,387	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 909,326	$ 2,132,288	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		485,009	13
14	Buildings, at Historical Cost		9,661,860	14
15	Leasehold Improvements, at Historical Cost	767,497	2,131,498	15
16	Equipment, at Historical Cost	289,161	289,161	16
17	Accumulated Depreciation (book methods)	(466,074)	(3,762,167)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		278,209	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(9,305)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,503,526	1,503,526	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,094,110	$ 10,577,791	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,003,436	$ 12,710,079	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,276,667	$ 1,328,711	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,108	21,108	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	177,529	177,529	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,427	4,427	31
32	Accrued Real Estate Taxes(Sch.IX-B)		229,222	32
33	Accrued Interest Payable		103,675	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	2,654,441	850,338	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,134,172	$ 2,715,010	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		26,191,564	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 26,191,564	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,134,172	$ 28,906,574	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,130,736)	$ (16,196,495)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,003,436	$ 12,710,079	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,550,963	1
2	Restatements (describe):		2
3	Payroll Taxes	161	3
4	Rounding	(2)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,551,122	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,706,858)	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	(975,000)	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)**	$ (2,681,858)	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)**	$ (1,130,736)	24 *

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	$ 7,850,914	1
2	Discounts and Allowances for all Levels	(5,822)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,845,092	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	5,822	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	20	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,842	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	See Supplemental Schedule	5,136	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,136	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,856,070	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,011,001	31
32	Health Care	3,056,736	32
33	General Administration	1,951,746	33
	B. Capital Expense		
34	Ownership	2,172,280	34
	C. Ancillary Expense		
35	Special Cost Centers	255,642	35
36	Provider Participation Fee	115,523	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,562,928	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,706,858)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,706,858)	43

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

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete 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. SEE ACCOUNTANTS' COMPILATION REPORT**

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,153	1,163	$ 53,607	$ 46.09	1
2	Assistant Director of Nursing	1,980	2,252	64,663	28.71	2
3	Registered Nurses	8,018	8,727	253,361	29.03	3
4	Licensed Practical Nurses	29,241	31,600	799,466	25.30	4
5	CNAs & Orderlies	68,534	75,352	793,300	10.53	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,100	1,544	21,724	14.07	9
10	Activity Assistants	14,191	16,146	177,401	10.99	10
11	Social Service Workers	29,960	33,072	557,389	16.85	11
12	Dietician					12
13	Food Service Supervisor	1,891	2,065	33,322	16.14	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,112	7,194	77,919	10.83	15
16	Dishwashers	18,686	19,862	189,929	9.56	16
17	Maintenance Workers	35,085	39,469	460,658	11.67	17
18	Housekeepers	17,719	21,037	203,575	9.68	18
19	Laundry					19
20	Administrator	1,822	2,161	117,564	54.40	20
21	Assistant Administrator	1,451	1,659	45,476	27.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,289	10,482	142,882	13.63	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	1,601	1,913	18,675	9.76	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	10,186	11,680	334,353	28.63	33
34	TOTAL (lines 1 - 33)	258,019	287,378	$ 4,345,264 *	$ 15.12	34

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	410	$ 22,743	01-03	35
36	Medical Director	Monthly	25,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant	44	1,958	10-03	38
39	Pharmacist Consultant	Monthly	8,353	10-03	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	178	8,913	12-03	45
46	Other(specify)				46
47	Psychiatrist	1,183	76,863	10-03	47
48	See Attached		10,913		48
49	TOTAL (lines 35 - 48)	1,815	$ 154,943		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

SEE ACCOUNTANTS' COMPILATION REPORT

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

** See instructions.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Blake A. Willey	Administrator	0	$ 117,564
Marion Holcomb	Asst. Admin	0	45,476
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 163,041

B. Administrative - Other

Description	Amount
	$
Management Fees - Dr. Jacob Bakst	25,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 25,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners, Inc.	Unemployment Consultant	$ 3,281
Prospect Resources	Energy Consultant	1,300
Michigan Peer Review Org.	Peer Review	680
Blymass	Tax Credits	480
Hamlin & Burton	Liability Management	690
First Real Estate Service	Real Estate Appraisal	2,750
Legat Architects	Architectural	2,827
National Hotline Services	Employee Compliance	218
Extended Care Consulting	Home Office Expense	186,604
Extended Care Clinical	Home Office Expense	116,477
Pinnacle Consulting	Customer Satisfaction	1,100
See Supplemetal Schedule		77,917
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 394,323

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,296
Unemployment Compensation Insurance	140,916
FICA Taxes	316,930
Employee Health Insurance	187,507
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Employer Taxes	4,722
Pension Expense	52,928
Other Employee Welfare	3,879
Holiday Expense	3,504
TOTAL (agree to Schedule V, line 22, col.8)	$ 801,682

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	385
Health Care Worker Background Check	3,574
(Indicate # of checks performed 105)	
Patient Background Checks 402	4,020
License & Fees	1,973
Dues & Subscriptions	15,659
Extended Care Consulting Allocation	3,311
Extended Care Clinical Allocation	186
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,103

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	675
Education	782
Inservices	5,290
See Supplemental Schedule	1,650
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,397

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/10 Ending: 12/31/10

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	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/10 **Ending:** 12/31/10

XX. GENERAL INFORMATION:

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

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(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? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **N/A**

(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. $ **115,523**
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. $ Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(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? **100% Ln 14**
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? **Yes**

(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.