FOR BHF USE

LL1

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

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

I. IDPH License ID Number: 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: 08/01/05

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: 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 01/01/11 to 12/31/11 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

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

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Lisa M. Hanlon, C.P.A.
(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: 01/01/11 Ending: 12/31/11

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 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	57,544	173		57,717	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,544	173		57,717	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.94%

D. How many bed-hold days during this year were paid by the Department?
55 (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 08/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/2005 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: 12/31/2011 Fiscal Year: 12/31/2011

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

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	278,674	29,807	21,395	329,876		329,876	8,649	338,525			1
2	Food Purchase		270,023		270,023		270,023	281	270,304			2
3	Housekeeping	239,749	91,586		331,335		331,335	(917)	330,418			3
4	Laundry	13,134	7,400	63,120	83,654		83,654	(59)	83,595			4
5	Heat and Other Utilities			165,752	165,752		165,752	(822)	164,930			5
6	Maintenance	304,280		183,753	488,033		488,033	(9,643)	478,390			6
7	Other (specify):*							3,220	3,220			7
8	**TOTAL General Services**	835,837	398,816	434,020	1,668,673		1,668,673	710	1,669,383			8
	B. Health Care and Programs											
9	Medical Director			13,700	13,700		13,700		13,700			9
10	Nursing and Medical Records	2,115,783	77,001	43,829	2,236,613		2,236,613	42,899	2,279,512			10
10a	Therapy											10a
11	Activities	194,778	12,789		207,567		207,567		207,567			11
12	Social Services	495,654	43,889	23,877	563,420		563,420	6,952	570,372			12
13	CNA Training											13
14	Program Transportation			510	510		510		510			14
15	Other (specify):*							12,862	12,862			15
16	**TOTAL Health Care and Programs**	2,806,215	133,679	81,916	3,021,810		3,021,810	62,713	3,084,523			16
	C. General Administration											
17	Administrative	169,689			169,689		169,689	54,992	224,681			17
18	Directors Fees											18
19	Professional Services			405,230	405,230	(185)	405,045	(292,872)	112,173			19
20	Dues, Fees, Subscriptions & Promotions			48,246	48,246		48,246	(15,032)	33,214			20
21	Clerical & General Office Expenses	146,268	26,992	62,183	235,443		235,443	125,740	361,183			21
22	Employee Benefits & Payroll Taxes			766,082	766,082		766,082	(11,421)	754,661			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,701	1,701		1,701	2,311	4,012			24
25	Other Admin. Staff Transportation			20,449	20,449		20,449	(8,011)	12,438			25
26	Insurance-Prop.Liab.Malpractice			140,775	140,775		140,775	1,056	141,831			26
27	Other (specify):*							28,885	28,885			27
28	**TOTAL General Administration**	315,957	26,992	1,444,666	1,787,615	(185)	1,787,430	(114,352)	1,673,078			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,958,009	559,487	1,960,602	6,478,098	(185)	6,477,913	(50,929)	6,426,984			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: 01/01/11 Ending: 12/31/11

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			123,626	123,626		123,626	224,936	348,562			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,244,782	1,244,782			32
33	Real Estate Taxes			(55)	(55)	185	130	328,792	328,922			33
34	Rent-Facility & Grounds			2,010,000	2,010,000		2,010,000	(2,010,000)				34
35	Rent-Equipment & Vehicles			12,648	12,648		12,648	(2,851)	9,797			35
36	Other (specify):*							130,098	130,098			36
37	**TOTAL Ownership**			2,146,219	2,146,219	185	2,146,404	(84,243)	2,062,161			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,070		2,070		2,070	(1,367)	703			39
40	Barber and Beauty Shops			230	230		230		230			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			369,389	369,389		369,389		369,389			42
43	Other (specify):*	49,880			49,880		49,880	(49,880)	0			43
44	**TOTAL Special Cost Centers**	49,880	2,070	369,619	421,569		421,569	(51,247)	370,322			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,007,889	561,557	4,476,440	9,045,886		9,045,886	(186,418)	8,859,468			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: 01/01/11 Ending: 12/31/11

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,083)	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	(33,150)	30		9
10	Interest and Other Investment Income	(200)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(8)	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	(1,090)	21		18
19	Entertainment				19
20	Contributions	(5,115)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(696)	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	(144,602)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (186,943)		$	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)	525		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 525		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (186,418)		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: 01/01/11

Ending: 12/31/11

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized R&M	$ (23,004)	06	1
2	Jury Duty Income	(17)	21	2
3	Insurance Refund	(65)	26	3
4	Patient Clothing	(1,218)	10	4
5	Theft Loss	(450)	21	5
6	Collections Expense	(2,821)	21	6
7	PPA - Professional Services	(18,964)	19	7
8	PPA - Achieve Reconciliation	(484)	21	8
9	Marketing Salary	(49,880)	43	9
10	Annual Report	(559)	20	10
11	Non-Allowable Marketing Travel	(8,515)	25	11
12	Non-Allowable Legal	(9,580)	19	12
13	Additional R&M	2,134	06	13
14	Building Co. - Audit Fee	(7,500)	19	14
15	Building Co. - Filing Fee	(250)	21	15
16	Building Co. - Amortization Expense	(8,302)	31	16
17	Non-Allowable Fee	(55)	21	17
18	Achieve Credit	(2,651)	21	18
19	Alliance for Living	(12,421)	20	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**	(144,602)		49

Rainbow Beach Care Center

ID# 0047332

Report Period Beginning: 01/01/11

Ending: 12/31/11

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

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 TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			301		8,407		(59)					8,649	1
2	Food Purchase	(8)		289									281	2
3	Housekeeping			609		109		(1,635)					(917)	3
4	Laundry							(59)					(59)	4
5	Heat and Other Utilities	(2,083)		1,069		192							(822)	5
6	Maintenance	(20,870)		3,068	8,120	39							(9,643)	6
7	Other (specify):*				1,805	1,415							3,220	7
8	**TOTAL General Services**	(22,961)		5,336	9,925	10,162		(1,752)					710	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,218)				46,908		(2,790)					42,899	10
10a	Therapy													10a
11	Activities													11
12	Social Services					6,952							6,952	12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*					9,066	3,796						12,862	15
16	**TOTAL Health Care and Programs**	(1,218)				62,926	3,796	(2,790)					62,713	16
	C. General Administration													
17	Administrative			3,205	10,914	40,873							54,992	17
18	Directors Fees													18
19	Professional Services	(36,044)	7,500	(212,564)		(51,764)							(292,872)	19
20	Fees, Subscriptions & Promotions	(18,791)		3,588		171							(15,032)	20
21	Clerical & General Office Expenses	(7,819)	250	13,292	111,562	8,456		(2)					125,740	21
22	Employee Benefits & Payroll Taxes				(7,599)		(3,796)	(26)					(11,421)	22
23	Inservice Training & Education													23
24	Travel and Seminar			198		2,113							2,311	24
25	Other Admin. Staff Transportation	(8,515)		504									(8,011)	25
26	Insurance-Prop.Liab.Malpractice	(65)		955		166							1,056	26
27	Other (specify):*				21,106	7,779							28,885	27
28	**TOTAL General Administration**	(71,233)	7,750	(190,822)	135,983	7,794	(3,796)	(28)					(114,352)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(95,412)	7,750	(185,486)	145,908	80,882		(4,571)					(50,929)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Rainbow Beach Care Center** **#** **0047332** **Report Period Beginning:** **01/01/11** **Ending:** **12/31/11**

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(33,150)	246,187	10,318		1,581							224,936	30
31	Amortization of Pre-Op. & Org.	(8,302)	8,302											31
32	Interest	(200)	1,235,705	8,776		501							1,244,782	32
33	Real Estate Taxes		326,926	1,582		284							328,792	33
34	Rent-Facility & Grounds		(2,010,000)										(2,010,000)	34
35	Rent-Equipment & Vehicles			3,911					(6,762)				(2,851)	35
36	Other (specify):*		130,098										130,098	36
37	**TOTAL Ownership**	(41,652)	(62,782)	24,587		2,366			(6,762)				(84,243)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers							(2)	(1,365)				(1,367)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(49,880)											(49,880)	43
44	**TOTAL Special Cost Centers**	(49,880)						(2)	(1,365)				(51,247)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(186,943)	(55,032)	(160,899)	145,908	83,248		(4,573)	(8,127)				(186,418)	45

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

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	Rental Income	$ 2,010,000	Rainbow Beach Real Estate	100.00%	$	$ (2,010,000)	1
2	V	32	Interest	259	Rainbow Beach Real Estate	100.00%	1,235,964	1,235,705	2
3	V	19	Audit Fee		Rainbow Beach Real Estate	100.00%	7,500	7,500	3
4	V	21	Filing Fee		Rainbow Beach Real Estate	100.00%	250	250	4
5	V	30	Depreciation Expense		Rainbow Beach Real Estate	100.00%	246,187	246,187	5
6	V	31	Amortization Expense		Rainbow Beach Real Estate	100.00%	8,302	8,302	6
7	V	33	Real Estate Taxes		Rainbow Beach Real Estate	100.00%	326,926	326,926	7
8	V	36	Mortgage Insurance Premium		Rainbow Beach Real Estate	100.00%	130,098	130,098	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,010,259			$ 1,955,227	$ * (55,032)	14

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

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%	$ 301	$ 301	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	289	289	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	609	609	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,069	1,069	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,068	3,068	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,205	3,205	20
21	V	19	Professional Fees	218,556	Extended Care Consulting, LLC	100.00%	5,992	(212,564)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	3,588	3,588	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	13,292	13,292	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	198	198	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	504	504	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	955	955	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	10,318	10,318	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	8,776	8,776	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	1,582	1,582	29
30	V	34	Rent - Building		Extended Care Consulting, LLC	100.00%			30
31	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	3,911	3,911	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 218,556			$ 57,657	$ * (160,899)	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: 01/01/11 Ending: 12/31/11

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%	8,120	$ 8,120	15
16	V	06	Maintenance (Direct)	2,435	Extended Care Consulting, LLC	100.00%	2,435		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,456	1,456	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	349	349	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%	10,914	10,914	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	111,562	111,562	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%	21,074	21,074	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	32	32	25
26	V	22	Employee Benefits	7,599	Extended Care Consulting, LLC	100.00%		(7,599)	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			$ 10,034			$ 155,942	$ * 145,908	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: 01/01/11 Ending: 12/31/11

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%	$ 109	$ 109	15
16	V	05	Utilities		Extended Care Clinical, LLC	100.00%	192	192	16
17	V	06	Maintenance		Extended Care Clinical, LLC	100.00%	39	39	17
18	V	19	Professional Fees	72,852	Extended Care Clinical, LLC	100.00%	21,088	(51,764)	18
19	V	20	Dues and Subscriptions		Extended Care Clinical, LLC	100.00%	171	171	19
20	V	21	Office & Clerical		Extended Care Clinical, LLC	100.00%	3,117	3,117	20
21	V	24	Travel and Seminar		Extended Care Clinical, LLC	100.00%	2,113	2,113	21
22	V	26	Insurance		Extended Care Clinical, LLC	100.00%	166	166	22
23	V	30	Depreciation		Extended Care Clinical, LLC	100.00%	1,581	1,581	23
24	V	32	Interest		Extended Care Clinical, LLC	100.00%	501	501	24
25	V	33	Real Estate Taxes		Extended Care Clinical, LLC	100.00%	284	284	25
26	V	01	Dietary Salary		Extended Care Clinical, LLC	100.00%	8,407	8,407	26
27	V	07	Emp. Ben. - Gen. Serv.		Extended Care Clinical, LLC	100.00%	1,415	1,415	27
28	V	10	Nursing Salary		Extended Care Clinical, LLC	100.00%	46,908	46,908	28
29	V	10a	Rehab Salary		Extended Care Clinical, LLC	100.00%			29
30	V	12	Social Service Salary		Extended Care Clinical, LLC	100.00%	6,952	6,952	30
31	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	9,066	9,066	31
32	V	17	Administration Salary		Extended Care Clinical, LLC	100.00%	40,873	40,873	32
33	V	21	Office Salary		Extended Care Clinical, LLC	100.00%	5,339	5,339	33
34	V	27	Emp. Ben. - Gen. Admin.		Extended Care Clinical, LLC	100.00%	7,779	7,779	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 72,852			$ 156,100	$ * 83,248	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: 01/01/11 Ending: 12/31/11

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 / Medical Record Salary	21,607	Extended Care Clinical, LLC	100.00%	21,607		17
18	V	12	Social Service / Admission Salary	13,939	Extended Care Clinical, LLC	100.00%	13,939		18
19	V	15	Emp. Ben. - Healthcare		Extended Care Clinical, LLC	100.00%	3,796	3,796	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	3,796	Extended Care Clinical, LLC	100.00%		(3,796)	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			$ 39,342			$ 39,342	$ *	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: 01/01/11 Ending: 12/31/11

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	$ 966	Xcel Supply, LLC	100.00%	$ 908	$ (59)	15
16	V	3	Housekeeping	26,968	Xcel Supply, LLC	100.00%	25,333	(1,635)	16
17	V	4	Laundry	969	Xcel Supply, LLC	100.00%	910	(59)	17
18	V	6	Repairs & Maintenance		Xcel Supply, LLC	100.00%			18
19	V	10	Nursing	46,029	Xcel Supply, LLC	100.00%	43,239	(2,790)	19
20	V	11	Activities		Xcel Supply, LLC	100.00%			20
21	V	21	Office And Clerical	29	Xcel Supply, LLC	100.00%	27	(2)	21
22	V	22	Employee Benefits	432	Xcel Supply, LLC	100.00%	406	(26)	22
23	V	30	Fixed Assets-Depreciation		Xcel Supply, LLC	100.00%			23
24	V	39	Ancillary	40	Xcel Supply, LLC	100.00%	37	(2)	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			$ 75,433			$ 70,860	$ * (4,573)	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: 01/01/11 Ending: 12/31/11

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	39	Ventilator Equipment	2,070	Vent Lease LLC	100.00%	705	(1,365)	15
16	V	39	Other Ancillary		Vent Lease LLC	100.00%			16
17	V	35	Matrix Leasing	6,762	Vent Lease LLC	100.00%		(6,762)	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			$ 8,832			$ 705	$ * (8,127)	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: 01/01/11 Ending: 12/31/11

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%	$ 77,547	$ 77,547	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	77,547	CCS Employee Benefits Group	100.00%		(77,547)	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			$ 77,547			$ 77,547	$ *	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: 01/01/11 Ending: 12/31/11

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

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

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	51.000%	WHEATON CARE CENTER	WHEATON	RAINBOW BEACH REAL ESTAT	EVANSTON	BUILDING CO.	1
2	GALE ROTHNER	49.000%	AVENUE CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKI	2
3			BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	EXTENDED CARE CLINICAL	EVANSTON	ADMINISTRATIVE	3
4			BOULEVARD CARE NURSING AND REHABILITATION CENTER,LLC	CHICAGO	CCS EMPLOYEE BENEFITS GR	EVANSTON	HEALTH INSURANCE	4
5			BRIAR PLACE, LTD.	INDIAN HEAD	XCEL MEDICAL SUPPLY	EVANSTON	MEDICAL SUPPLIES	5
6			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	VENTLEASE, LLC	EVANSTON	VENTILATOR RENTAL	6
7			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	2201 MAIN, LLC	EVANSTON	BLDG COMPANY	7
8			DYER NURSING & REHAB	DYER, IN				8
9			GRASMERE PLACE, LLC	CHICAGO				9
10			HILLCREST NURSING AND REHABILITATION CENTER,LLC	JOLIET				10
11			HOMESTEAD NURSING & REHAB	LINCOLN, NE				11
12			GOLDEN PLAINES	HUTCHINSON, KS				12
13			LAKE COUNTY NURSING & REHAB	EAST CHICAGO, IN				13
14			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				14
15			LANCASTER MANOR	LINCOLN, NE				15
16			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				16
17			MCKINLEY HEALTH CARE CENTER	CANTON, OH				17
18			OAK PARK HEALTHCARE CENTER, L.L.C.	OAK PARK				18
19			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				19
20			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				20
21			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				21
22			SEBOS NURSING & REHAB	HOLBART, IN				22
23			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				23
24			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				24
25			SNOW VALLEY NURSING AND REHABILITATION CENTER, L.L.C.	LISLE				25
26			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				26
27			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				27
28								28
29								29
30								30

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES

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

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VII. RELATED PARTIES (continued)

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

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

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	G. Matt Silvers	Relative	Administrative	0.00%	See Attached	0.24	0.60%	Alloc. Salary	$ 946	17-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	3.8	6.91%	Al Sal/Al Fees	12,442	17-7	2
3	Adam Vales	Relative	Clerical	0.00%	See Attached	0.57	1.43%	Alloc. Salary	1,012	22-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 14,400		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: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,332,501	31	$ 6,942	$	57,717	$ 301	1
2	02	Food	Patient Days	1,332,501	31	6,677		57,717	289	2
3	03	Housekeeping	Patient Days	1,332,501	31	14,059		57,717	609	3
4	05	Utilities	Patient Days	1,332,501	31	24,674		57,717	1,069	4
5	06	Maintenance	Patient Days	1,332,501	31	70,833		57,717	3,068	5
6	17	Administrative	Patient Days	1,332,501	31	74,000		57,717	3,205	6
7	19	Professional Fees	Patient Days	1,332,501	31	138,332		57,717	5,992	7
8	20	Dues and Subscriptions	Patient Days	1,332,501	31	82,842		57,717	3,588	8
9	21	Office and Clerical	Patient Days	1,332,501	31	306,863		57,717	13,292	9
10	24	Seminar and Travel	Patient Days	1,332,501	31	4,580		57,717	198	10
11	25	Other Staff Admin. Trans.	Patient Days	1,332,501	31	11,637		57,717	504	11
12	26	Insurance	Patient Days	1,332,501	31	22,043		57,717	955	12
13	30	Depreciation	Patient Days	1,332,501	31	238,204		57,717	10,318	13
14	32	Interest	Patient Days	1,332,501	31	202,602		57,717	8,776	14
15	33	Real Estate Taxes	Patient Days	1,332,501	31	36,524		57,717	1,582	15
16	34	Rent - Building	Patient Days	1,332,501	31			57,717		16
17	35	Rent - Equipment & Auto	Patient Days	1,332,501	31	90,286		57,717	3,911	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,331,096	$		$ 57,657	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	1,332,501	31	187,474	187,474	57,717	8,120	1
2	06	Maintenance (Direct)	Direct		31	122,603	122,603		2,435	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,332,501	31	33,619		57,717	1,456	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	16,441			349	4
5	12	Admission (Direct)	Direct		31					5
6	15	Emp. Ben. - Nursing (Direct)	Direct		31					6
7	17	Administrative (Pooled)	Patient Days	1,332,501	31	251,959	251,959	57,717	10,914	7
8	21	Office and Clerical (Pooled)	Patient Days	1,332,501	31	2,575,611	2,575,611	57,717	111,562	8
9	21	Office and Clerical (Direct)	Direct		31	545,076	545,076			9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,332,501	31	486,522		57,717	21,074	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	78,893			32	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					$ 4,298,198	$ 3,682,723		$ 155,942	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	817,528	19	$ 1,549	$	57,717	$ 109	1
2	05	Utilities	Patient Days	817,528	19	2,718		57,717	192	2
3	06	Maintenance	Patient Days	817,528	19	557		57,717	39	3
4	19	Professional Fees	Patient Days	817,528	19	298,695		57,717	21,088	4
5	20	Dues and Subscriptions	Patient Days	817,528	19	2,426		57,717	171	5
6	21	Office & Clerical	Patient Days	817,528	19	44,146		57,717	3,117	6
7	24	Travel and Seminar	Patient Days	817,528	19	29,934		57,717	2,113	7
8	26	Insurance	Patient Days	817,528	19	2,346		57,717	166	8
9	30	Depreciation	Patient Days	817,528	19	22,389		57,717	1,581	9
10	32	Interest	Patient Days	817,528	19	7,100		57,717	501	10
11	33	Real Estate Taxes	Patient Days	817,528	19	4,024		57,717	284	11
12	01	Dietary Salary	Patient Days	817,528	19	119,073	119,073	57,717	8,407	12
13	07	Emp. Ben. - Gen. Serv.	Patient Days	817,528	19	20,044		57,717	1,415	13
14	10	Nursing Salary	Patient Days	817,528	19	664,429	664,429	57,717	46,908	14
15	10a	Rehab Salary	Patient Days	817,528	19			57,717		15
16	12	Social Service Salary	Patient Days	817,528	19	98,474	98,474	57,717	6,952	16
17	15	Emp. Ben. - Healthcare	Patient Days	817,528	19	128,421		57,717	9,066	17
18	17	Administration Salary	Patient Days	817,528	19	578,938	578,938	57,717	40,873	18
19	21	Office Salary	Patient Days	817,528	19	75,625	75,625	57,717	5,339	19
20	27	Emp. Ben. - Gen. Admin.	Patient Days	817,528	19	110,184		57,717	7,779	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,211,073	$ 1,536,540		$ 156,100	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$	1
2	07	Emp. Ben. - General	Direct Allocation							2
3	10	Nursing / Medical Record Salary	Direct Allocation			344,209	344,209		21,607	3
4	12	Social Service / Admission Salary	Direct Allocation			174,668	174,668		13,939	4
5	15	Emp. Ben. - Healthcare	Direct Allocation			61,656			3,796	5
6	17	Administration Salary	Direct Allocation							6
7	27	Emp. Ben. - Gen. Admin.	Direct Allocation							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					$ 580,533	$ 518,877		$ 39,342	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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			$	$		$ 908	1
2	3	Housekeeping	Direct Allocation						25,333	2
3	4	Laundry	Direct Allocation						910	3
4	6	Repairs & Maintenance	Direct Allocation							4
5	10	Nursing	Direct Allocation						43,239	5
6	11	Activities	Direct Allocation							6
7	21	Office And Clerical	Direct Allocation						27	7
8	22	Employee Benefits	Direct Allocation						406	8
9	30	Fixed Assets-Depreciation	Direct Allocation							9
10	39	Ancillary	Direct Allocation						37	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					$	$		$ 70,860	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [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	39	Ventilator Equipment	Direct Allocation						705	1
2	39	Other Ancillary	Direct Allocation							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					$	$		$ 705	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES 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			$	$		$ 77,547	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					$	$		$ 77,547	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 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: 01/01/11 Ending: 12/31/11

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** 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			$	$ 25,873,051			$ 1,235,964	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	Private Bank		X	Line of Credit								6
7	VGM Financial		X	Note Payable								7
8	See Supplemental Schedule											8
9	TOTAL Facility Related						$	$ 25,873,051			$ 1,235,964	9
	B. Non-Facility Related*											
10	Interest Income - Facility		X								(200)	10
11	Interest Income - Bldg Co		X								(259)	11
12	Dowd, Block & Bennett		X	Welfare & Pension Funds								12
13	See Supplemental Schedule										9,277	13
14	TOTAL Non-Facility Related						$	$			$ 8,818	14
15	TOTALS (line 9+line14)						$	$ 25,873,051			$ 1,244,781	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 130,098 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: 01/01/11 Ending: 12/31/11

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	EC Consulting Allocation		X				$	$			$ 8,776	15
16	EC Clinical Allocation		X								501	16
17												17
18												18
19												19
20	TOTAL Non-Facility Related										9,277	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:** 01/01/11 **Ending:** 12/31/11

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2010 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$	229,222	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.)	$	273,131	2
3. Under or (over) accrual (line 2 minus line 1).	$	43,909	3
4. Real Estate Tax accrual used for 2011 report. (Detail and explain your calculation of this accrual on the lines below.)	$	284,828	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.**	$	185	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	328,922	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2006	206,813	8
2007	204,605	9
2008	206,658	10
2009	218,307	11
2010	271,265	12

2011 Accrual =$271,265 x 1.05 = $284,828
Allocated from Extended Care Consulting = $1,582
Allocated from Extended Care Clinical = $284

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

NOTES:

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

2010 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME 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 2010 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2010.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-30-112-004-0000	Long Term Care Property	$ 1,576.08	$ 1,576.08
2.	21-30-112-007-0000	Long Term Care Property	$ 40,813.76	$ 40,813.76
3.	21-30-112-008-0000	Long Term Care Property	$ 45,880.88	$ 45,880.88
4.	21-30-112-011-0000	Long Term Care Property	$ 272.59	$ 272.59
5.	21-30-112-012-0000	Long Term Care Property	$ 272.59	$ 272.59
6.	21-30-112-013-0000	Long Term Care Property	$ 38,642.63	$ 38,642.63
7.	21-30-112-014-0000	Long Term Care Property	$ 48,932.48	$ 48,932.48
8.	21-30-112-017-0000	Long Term Care Property	$ 820.62	$ 820.62
9.	21-30-112-018-0000	Long Term Care Property	$ 825.84	$ 825.84
10.	21-30-112-051-0000	Long Term Care Property	$ 86,924.29	$ 86,924.29
		TOTALS	$ 264,961.76	$ 264,961.76

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

C. **Tax Bills**

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

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

2000 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

TELEPHONE ( ) FAX #: ( )

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

Enter the tax index number and real estate tax assessed for 2000 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 2000.

	(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	$ 6,303.25	$ 6,303.25
2.	See Attached	2201 Main Allocation	$ 126,481.18	$ 2,605.26
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 132,784.43	$ 8,908.51

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 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

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			16,890	2
3	TOTALS			$ 501,899	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211			1960	$ 9,549,265	$ 246,187	39	$ 244,853	$ (1,334)	$ 1,713,971	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	39,668		20	1,983	1,983	12,231	9
10	Various			2006	338,166		20	20,751	20,751	155,650	10
11	Various			2007	131,026		20	10,294	10,294	44,834	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	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)								67
68	Related Party Allocations (Pages 12H & 12I)		68,439	4,651		4,651		37,087	68
69	Financial Statement Depreciation			123,626			(123,626)		69
70	TOTAL (lines 4 thru 69)		$ 10,126,564	$ 374,464		$ 282,532	$ (91,932)	$ 1,963,773	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,126,564	$ 374,464		$ 282,532	$ (91,932)	$ 1,963,773	1
2	Door Replacement	2008	5,785		20	289	289	1,157	2
3	Expansion Tank	2008	4,311		20	216	216	862	3
4	Replacing Boards And Parts On Elevator	2008	3,770		20	189	189	738	4
5	Replaced Parts For Elevator Due To Water Damage	2008	6,010		20	301	301	1,177	5
6	Adj #54 - Proceeds From Insurance	2008	(2,234)		20	(112)	(112)	(437)	6
7	Doors	2008	6,145		20	307	307	1,178	7
8	Steel Doors	2008	5,220		20	261	261	957	8
9	Water Heater	2008	11,588		20	2,318	2,318	8,498	9
10	Installation Of New Washer & Dryer	2008	2,000		20	400	400	1,433	10
11	Work On Elevator Shaft	2008	28,480		20	1,424	1,424	5,103	11
12	Elevator Installation	2008	111,525		20	5,576	5,576	19,982	12
13	New Laundry Rooms	2008	12,150		20	608	608	2,126	13
14	Elevator Repair	2008	15,000		20	750	750	2,563	14
15	Roof Repairs	2008	4,600		20	230	230	748	15
16	Replaced 2 Rooftop Hvac Units	2008	15,985		20	799	799	2,598	16
17	Elevator Pit Repairs	2008	20,000		20	1,000	1,000	3,167	17
18	Elevator Shaft Repair	2009	28,000		20	1,400	1,400	3,500	18
19	Elevator Door Repair	2009	3,120		20	156	156	390	19
20	Replace Relief Valves On Trane Chiller	2009	4,828		20	966	966	2,414	20
21	Elevator Shaft Repair	2009	20,000		20	1,000	1,000	3,000	21
22	Hot Water Coil	2009	4,487		20	897	897	2,692	22
23	Elevator Fire Alarm	2009	7,735		20	387	387	1,031	23
24	Replace Train Hot Water Coil	2009	3,877		20	775	775	1,809	24
25	Installation Of 2 Metal Doors	2009	8,500		20	425	425	1,027	25
26	Elevator Shaft Repair	2009	25,000		20	1,250	1,250	3,646	26
27	Cubicle Curtain	2009	6,807		20	681	681	1,985	27
28	Elevator Shaft	2009	(14,240)		20	(1,424)	(1,424)	(2,967)	28
29	Valves And Gaskets	2010	3,186		20	159	159	265	29
30	Door And Frame	2010	3,100		20	155	155	245	30
31	Metal Door And Frame	2010	7,985		20	399	399	632	31
32	Fire Dampers	2010	3,330		20	166	166	222	32
33	Stairwell Locks	2010	4,475		20	224	224	280	33
34	TOTAL (lines 1 thru 33)		$ 10,497,088	$ 374,464		$ 304,704	$ (69,760)	$ 2,035,794	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,497,088	$ 374,464		$ 304,704	$ (69,760)	$ 2,035,794	1
2	Generator Repairs	2010	2,772		20	139	139	150	2
3	Fire Dampers	2010	3,330		20	166	166	180	3
4	Replace Trane Hot Water Coil	2011	8,680		20	1,736	1,736	1,736	4
5	Drain & Duct Work	2011	15,800		20	593	593	593	5
6	Painting	2011	6,503		20	3,793	3,793	3,793	6
7	Replace Outer Coil In Trane Chiller	2011	27,220		20	681	681	681	7
8	New Floor	2011	5,363		20	112	112	112	8
9	Hail Damage	2011	(22,220)		20	(463)	(463)	(463)	9
10	Fire Rated Steel Door	2011	3,550		20	44	44	44	10
11	Install Fire Dampers On 5Th Floor	2011	9,382		20	78	78	78	11
12	Fire Rated Steel Door With Window	2011	3,770		20	189	189	189	12
13	Leaking Jack Unit - Elevator	2011	3,350		20	168	168	168	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)		$ 10,564,588	$ 374,464		$ 311,938	$ (62,526)	$ 2,043,054	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 10,564,588	$ 374,464		$ 311,938	$ (62,526)	$ 2,043,054	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,564,588	$ 374,464		$ 311,938	$ (62,526)	$ 2,043,054	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 10,564,588	$ 374,464		$ 311,938	$ (62,526)	$ 2,043,054	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
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 10,564,588	$ 374,464		$ 311,938	$ (62,526)	$ 2,043,054	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company Information								1
2	Buildings:								2
3									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
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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									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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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
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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)		$	$		$	$	$	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party Information		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Extended Care Consulting 2201 Main, LLC	2002	19,773	506	39	506		4,701	3
4	Allocated from Extended Care Clinical 2201 Main, LLC	2002	3,543	91	39	91		844	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	199	10	20	10		50	9
10	Allocated from Extended Care Consulting, LLC	2009	119	6	20	6		18	10
11	Allocated from Extended Care Consulting, LLC	2010	1,169	58	20	58		117	11
12	Allocated from Extended Care Consulting, LLC	2011	421	21	20	21		21	12
13									13
14									14
15	Allocated from Extended Care Consulting 2201 Main, LLC	2002	16,301	1,490	20	1,490		11,932	15
16	Allocated from Extended Care Consulting 2201 Main, LLC	2003	19,210	1,756	20	1,756		14,061	16
17	Allocated from Extended Care Consulting 2201 Main, LLC	2005	954	101	20	101		547	17
18	Allocated from Extended Care Consulting 2201 Main, LLC	2009	172	9	20	9		26	18
19									19
20									20
21	Allocated from Extended Care Clinical 2201 Main, LLC	2002	2,927	268	20	268		2,142	21
22	Allocated from Extended Care Clinical 2201 Main, LLC	2003	3,449	315	20	315		2,525	22
23	Allocated from Extended Care Clinical 2201 Main, LLC	2005	171	18	20	18		98	23
24	Allocated from Extended Care Clinical 2201 Main, LLC	2009	31	2	20	2		5	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	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
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (12H & 12I lines 1 thru 33)		$ 68,439	$ 4,651		$ 4,651	$	$ 37,087	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: 01/01/11 Ending: 12/31/11

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 223,061	$ 6,227	$ 35,093	$ 28,866	10	$ 180,701	71
72	Current Year Purchases	5,241	14	524	510	10	524	72
73	Fully Depreciated Assets	134,166				10	134,166	73
74								74
75	TOTALS	$ 362,468	$ 6,241	$ 35,617	$ 29,376		$ 315,391	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Cc	2011	$ 1,088	$ 218	$ 218	$	5	$ 870	76
77		Allocated from Extended Care Cc	2011	12,841				5	12,841	77
78		Allocated from Extended Care Cl	2011	3,946	789	789		5	2,631	78
79										79
80	TOTALS			$ 17,875	$ 1,007	$ 1,007	$		$ 16,342	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)	$ 11,446,831	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 381,712	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 348,562	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (33,150)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,374,787	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: 01/01/11 Ending: 12/31/11

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								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

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

	Fiscal Year Ending	Annual Rent
12.	/2012	$
13.	/2013	$
14.	/2014	$

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

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 9,797 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			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		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						2,070		2,070	13
14	TOTAL			$		$	$ 2,070		$ 2,070	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: 01/01/11 Ending: 12/31/11

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/11 (last day of reporting year)

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

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 112,427	1
2	Cash-Patient Deposits	44,428	44,428	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,128,745	1,128,745	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	311,461	429,350	6
7	Other Prepaid Expenses	2,493	2,493	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		1,033,276	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,487,127	$ 2,750,719	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	805,890	2,169,891	15
16	Equipment, at Historical Cost	296,395	296,395	16
17	Accumulated Depreciation (book methods)	(589,700)	(4,133,728)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		280,888	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(17,607)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,507,857	1,507,857	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,020,442	$ 10,250,565	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,507,569	$ 13,001,284	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,901,546	$ 3,901,546	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,618	14,618	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	216,855	216,855	30
31	Accrued Taxes Payable (excluding real estate taxes)	5,157	5,157	31
32	Accrued Real Estate Taxes(Sch.IX-B)		284,828	32
33	Accrued Interest Payable		102,414	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	1,756,602	2,499	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,894,778	$ 4,527,917	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		25,873,051	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)**	$	$ 25,873,051	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,894,778	$ 30,400,968	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,387,209)	$ (17,399,684)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,507,569	$ 13,001,284	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,130,736)	1
2	Restatements (describe):		2
3	Rounding	9	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,130,727)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,256,482)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,256,482)	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)**	$ (2,387,209)	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: 01/01/11 Ending: 12/31/11

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

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

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,786,471	1
2	Discounts and Allowances for all Levels	(22,043)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,764,428	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	22,043	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 22,043	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	200	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 200	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	2,733	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,733	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,789,404	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,668,673	31
32	Health Care	3,021,810	32
33	General Administration	1,787,615	33
	B. Capital Expense		
34	Ownership	2,146,219	34
	C. Ancillary Expense		
35	Special Cost Centers	52,180	35
36	Provider Participation Fee	369,389	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,045,886	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,256,482)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,256,482)	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: 01/01/11 Ending: 12/31/11

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,045	2,174	$ 98,886	$ 45.49	1
2	Assistant Director of Nursing	2,392	2,691	83,288	30.95	2
3	Registered Nurses	9,026	9,997	282,951	28.30	3
4	Licensed Practical Nurses	28,556	31,206	800,657	25.66	4
5	CNAs & Orderlies	60,090	66,950	707,882	10.57	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,071	2,303	33,247	14.44	9
10	Activity Assistants	11,432	13,138	161,531	12.29	10
11	Social Service Workers	21,615	24,251	453,256	18.69	11
12	Dietician					12
13	Food Service Supervisor	1,830	2,130	35,081	16.47	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,976	6,654	71,196	10.70	15
16	Dishwashers	15,454	17,537	172,397	9.83	16
17	Maintenance Workers	21,807	23,426	304,280	12.99	17
18	Housekeepers	22,753	24,899	239,749	9.63	18
19	Laundry	1,031	1,324	13,134	9.92	19
20	Administrator	1,884	2,114	108,337	51.25	20
21	Assistant Administrator	1,983	2,210	61,352	27.76	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,849	11,108	146,268	13.17	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	1,266	1,508	27,625	18.32	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	15,525	17,401	206,770	11.88	33
34	TOTAL (lines 1 - 33)	236,585	263,021	$ 4,007,887 *	$ 15.24	34

SEE ACCOUNTANTS' COMPILATION REPORT

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	417	$ 21,395	01-03	35
36	Medical Director	Monthly	13,700	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	10,472	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	199	9,938	12-03	45
46	Other(specify)				46
47	Psychiatrist	Monthly	11,750	10-03	47
48	See Attached		35,546		48
49	TOTAL (lines 35 - 48)	616	$ 102,801		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

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Blake Willey (01/01/2011-08/31/2011)	Administrator	0.00%	$ 75,790
Jacqueline Gully	Administrator	0.00%	32,547
Marlon Holcomb	Assist. Admin.	0.00%	61,352
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 169,689

B. Administrative - Other

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

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal Fees	$ 24,864
Frost, Ruttenberg & Rothblatt	Accounting	36,574
Personnel Planners, Inc.	Unemployment Consulting	2,755
Extended Care Consulting	Home Office Expense	218,556
Extended Care Clinical	Home Office Expense	72,852
National Hotline Services	Employee Compliance	415
Prospect Resources	Energy Consultant	1,300
Pinnacle Consulting	Customer Satisfaction	1,334
Moshe Calamaro & Associates	Structural Engineering	4,469
KTP Enterprises	Pavement & Site Consulting	200
Blymass	Tax Consulting	848
See Supplemetal Schedule		41,062
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 405,231

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 120,013
Unemployment Compensation Insurance	123,641
FICA Taxes	299,659
Employee Health Insurance	168,201
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Employer Taxes	3,536
Pension Expense	31,553
Other Employee Welfare	5,009
Holiday Expense	3,050
TOTAL (agree to Schedule V, line 22, col.8)	$ 754,662

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	$ 882
Advertising: Employee Recruitment	338
Health Care Worker Background Check	10,886
(Indicate # of checks performed 185)	
Patient Background Checks 250	2,500
Dues & Subscriptions	10,562
Licenses & Fees	4,287
Advertising & Promotions	696
Extended Care Consulting Allocation	3,588
See Supplemental Schedule	171
Less: Public Relations Expense	( )
Non-allowable advertising	(696)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,214

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,701
Extended Care Consulting Allocation	198
Extended Care Clinical Allocation	2,113
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,012

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/11 Ending: 12/31/11

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

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

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rainbow Beach Care Center **#** 0047332 **Report Period Beginning:** 01/01/11 **Ending:** 12/31/11

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. $ **120** Line **10**

(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. $ **369,389**
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.

SEE ACCOUNTANTS' COMPILATION REPORT

(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.