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.

2014
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2014)

I. IDPH License ID Number: 0047332

Facility Name: Rainbow Beach Care Center

Address: 7325 S Exchange St (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: 8/1/2005

Type of Ownership:

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

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236-1111
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/14 to 12/31/14 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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	64,324			64,324	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,324			64,324	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.52%

D. How many bed-hold days during this year were paid by the Department?
None (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 ____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/14 Fiscal Year: 12/31/14

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	290,544	35,519	18,690	344,753		344,753	209	344,962			1
2	Food Purchase		342,870		342,870		342,870	933	343,803			2
3	Housekeeping	268,929	70,834		339,763		339,763	698	340,461			3
4	Laundry		8,334	63,595	71,929		71,929		71,929			4
5	Heat and Other Utilities			192,902	192,902		192,902	(1,136)	191,766			5
6	Maintenance	333,495		187,009	520,504		520,504	39,974	560,478			6
7	Other (specify):*							1,305	1,305			7
8	TOTAL General Services	892,968	457,557	462,196	1,812,721		1,812,721	41,983	1,854,704			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,128,469	84,238	33,100	2,245,807		2,245,807	(3,110)	2,242,697			10
10a	Therapy											10a
11	Activities	208,370	13,602		221,972		221,972		221,972			11
12	Social Services	613,559	40,671		654,230		654,230		654,230			12
13	CNA Training											13
14	Program Transportation			2,391	2,391		2,391		2,391			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,950,398	138,511	42,691	3,131,600		3,131,600	(3,110)	3,128,490			16
	C. General Administration											
17	Administrative	171,601			171,601		171,601	27,660	199,261			17
18	Directors Fees											18
19	Professional Services			462,222	462,222	(6,076)	456,146	(365,474)	90,672			19
20	Dues, Fees, Subscriptions & Promotions			79,972	79,972		79,972	(34,448)	45,524			20
21	Clerical & General Office Expenses	111,767	26,808	290,075	428,650		428,650	(62,088)	366,562			21
22	Employee Benefits & Payroll Taxes			775,348	775,348		775,348	(5,512)	769,836			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,738	3,738		3,738	359	4,097			24
25	Other Admin. Staff Transportation			20,775	20,775		20,775	1,763	22,538			25
26	Insurance-Prop.Liab.Malpractice			234,761	234,761		234,761	29,315	264,076			26
27	Other (specify):*							31,106	31,106			27
28	TOTAL General Administration	283,368	26,808	1,866,891	2,177,067	(6,076)	2,170,991	(377,319)	1,793,672			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,126,734	622,876	2,371,778	7,121,388	(6,076)	7,115,312	(338,446)	6,776,866			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rainbow Beach Care Center #0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			101,669	101,669		101,669	237,916	339,585			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,187,887	1,187,887			32
33	Real Estate Taxes					6,076	6,076	262,826	268,902			33
34	Rent-Facility & Grounds			2,082,000	2,082,000		2,082,000	(2,082,000)				34
35	Rent-Equipment & Vehicles			5,646	5,646		5,646	1,037	6,683			35
36	Other (specify):*							124,954	124,954			36
37	**TOTAL Ownership**			2,189,315	2,189,315	6,076	2,195,391	(267,380)	1,928,011			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			61	61		61		61			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			61	61		61		61			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,126,734	622,876	4,561,154	9,310,764		9,310,764	(605,827)	8,704,937			45

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,710)	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	(14,112)	30		9
10	Interest and Other Investment Income	(126)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14,930)	21		18
19	Entertainment				19
20	Contributions	(22,579)	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	(204,697)	21		24
25	Fund Raising, Advertising and Promotional	(2,469)	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	(40,587)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (302,210)		$	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)	(303,616)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (303,616)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (605,827)		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

Rainbow Beach Care Center

ID# 0047332

Report Period Beginning: 01/01/14

Ending: 12/31/14

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Annual Report	$ (500)	20	1
2	Misc Income	(309)	21	2
3	Additional R&M	2,088	06	3
4	Jury Duty Income	(69)	10	4
5	Patient Clothing	(901)	10	5
6	Non Allowable Legal	(26,992)	19	6
7	Theft Loss	(652)	21	7
8	Collection Expense	(2,251)	21	8
9	Bldg Co. - Filing Fee	(250)	21	9
10	Bldg Co. - Amortization	(8,025)	31	10
11	Bldg Co. - Audit Fee	(7,900)	19	11
12	Alliance for Living PAC Dues	(11,194)	20	12
13	Bldg Co.- Bookkeeping Fee	(2,638)	19	13
14	Bldg Co.- Professional Fee	(1,000)	19	14
15	Prior Year Professional Fees	(58)	19	15
16	Bldg. Co.- RE Tax - Convenience Fee	(132)	33	16
17	Capitalized R&M	20,196	06	17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(40,587)		49

Rainbow Beach Care Center

ID# 0047332

Report Period Beginning: 01/01/14

Ending: 12/31/14

	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	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			209									209	1
2	Food Purchase			933									933	2
3	Housekeeping			698									698	3
4	Laundry													4
5	Heat and Other Utilities	(2,710)		1,574									(1,136)	5
6	Maintenance	22,284		6,496	11,194								39,974	6
7	Other (specify):*				1,305								1,305	7
8	**TOTAL General Services**	19,574		9,910	12,499								41,983	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(970)		(2,119)		(21)							(3,110)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(970)		(2,119)		(21)							(3,110)	16
	C. General Administration													
17	Administrative			4,317	23,343								27,660	17
18	Directors Fees													18
19	Professional Services	(38,588)	17,394	(344,280)									(365,474)	19
20	Fees, Subscriptions & Promotions	(36,742)		2,294									(34,448)	20
21	Clerical & General Office Expenses	(223,089)	250	15,705	145,046								(62,088)	21
22	Employee Benefits & Payroll Taxes				(5,512)								(5,512)	22
23	Inservice Training & Education													23
24	Travel and Seminar			359									359	24
25	Other Admin. Staff Transportation			1,763									1,763	25
26	Insurance-Prop.Liab.Malpractice		27,420	1,895									29,315	26
27	Other (specify):*				31,106								31,106	27
28	**TOTAL General Administration**	(298,419)	45,064	(317,947)	193,983								(377,319)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(279,815)	45,064	(310,156)	206,482	(21)							(338,446)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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	(14,112)	246,187	5,841									237,916	30
31	Amortization of Pre-Op. & Org.	(8,025)	8,025											31
32	Interest	(126)	1,186,676	1,337									1,187,887	32
33	Real Estate Taxes	(132)	259,554	3,404									262,826	33
34	Rent-Facility & Grounds		(2,082,000)										(2,082,000)	34
35	Rent-Equipment & Vehicles			1,037									1,037	35
36	Other (specify):*		124,954										124,954	36
37	**TOTAL Ownership**	(22,395)	(256,604)	11,619									(267,380)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(302,210)	(211,540)	(298,537)	206,482	(21)							(605,827)	45

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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 Pg 6-Supplemental		See Pg 6-Supplemental		See Pg 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	Rent	$ 2,082,000	Rainbow Beach Real Estate	100.00%	$	$ (2,082,000)	1
2	V	32	Interest	417	Rainbow Beach Real Estate	100.00%		(417)	2
3	V	19	Audit Fee/Bookkeeping Fee		Rainbow Beach Real Estate	100.00%	10,538	10,538	3
4	V	21	Filing Fee		Rainbow Beach Real Estate	100.00%	250	250	4
5	V	31	Amortization		Rainbow Beach Real Estate	100.00%	8,025	8,025	5
6	V	33	Real Estate Tax		Rainbow Beach Real Estate	100.00%	259,554	259,554	6
7	V	30	Depreciation		Rainbow Beach Real Estate	100.00%	246,187	246,187	7
8	V	26	Insurance		Rainbow Beach Real Estate	100.00%	27,420	27,420	8
9	V	32	Interest Expense - HUD		Rainbow Beach Real Estate	100.00%	1,187,093	1,187,093	9
10	V	36	Mortgage Insurance Premium		Rainbow Beach Real Estate	100.00%	124,954	124,954	10
11	V	19	Professional Fees		Rainbow Beach Real Estate	100.00%	1,000	1,000	11
12	V	19	R/E Tax Appeal		Rainbow Beach Real Estate	100.00%	5,856	5,856	12
13	V		R/E Tax Refund	16,209	Rainbow Beach Real Estate	100.00%		(16,209)	13
14	Total			$ 2,098,626			$ 1,870,877	$ * (227,749)	14

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 209	$ 209	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	933	933	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	698	698	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,574	1,574	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	6,496	6,496	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,317	4,317	20
21	V	19	Professional Fees	356,592	Extended Care Consulting, LLC	100.00%	12,312	(344,280)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	2,294	2,294	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	15,705	15,705	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	359	359	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,763	1,763	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,895	1,895	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	5,841	5,841	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	1,337	1,337	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	3,404	3,404	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,037	1,037	30
31	V								31
32	V	10	MDS	2,119	Extended Care Consulting, LLC	100.00%		(2,119)	32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 358,711			$ 60,174	$ * (298,537)	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	11,194	$ 11,194	15
16	V	06	Maintenance (Direct)	1,934	Extended Care Consulting, LLC	100.00%	1,934		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,062	1,062	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	243	243	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	23,343	23,343	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	136,964	136,964	22
23	V	21	Office and Clerical (Direct)	8,355	Extended Care Consulting, LLC	100.00%	16,437	8,082	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	29,527	29,527	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,579	1,579	25
26	V	22	Employee Benefits	5,512	Extended Care Consulting, LLC	100.00%		(5,512)	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			$ 15,801			$ 222,283	$ * 206,482	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	10	Rehab	300	Tri Care Rehab	100.00%	279	(21)	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			$ 300			$ 279	$ * (21)	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	$ 62,604	$ 62,604	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	62,604	CCS Employee Benefits Group	100.00%		(62,604)	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			$ 62,604			$ 62,604	$ *	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ 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.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	RAINBOW BEACH REAL ESTATE INVESTMENT VENTURE ONE, LL		BUILDING CO.	1
2	GALE ROTHNER	49.000%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTIN	EVANSTON	MANAGEMENT/BOOKKI	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING LL	EVANSTON	HEALTH INSURANCE	4
5			GRASMERE PLACE, LLC	CHICAGO	TRICARE REHAB	HILLSIDE	THERAPY	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD				6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				7
8			MAJOR HOSPITAL DYER	DYER, IN				8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER,LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			SHEFFIELD MANOR	DYER, IN				17
18			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				18
19			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				19
20			ST. JAMES WELLNESS REHAB VILLAS	CRETE				20
21			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				21
22			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				22
23			WHEATON CARE CENTER	WHEATON				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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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	Adam Vales	Relative	Clerical	0.00%	See Attached	0.54	1.35%	Alloc. Salary	$ 997	22-7	1
2	Mark Steinberg	Relative	Administrative	0.00%	See Attached	3.79	6.89%	Al Sal/Al Fees	13,765	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 14,762		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: 01/01/14 Ending: 12/31/14

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,251,572	31	$ 4,057	$	64,324	$ 209	1
2	02	Food	Patient Days	1,251,572	31	18,150		64,324	933	2
3	03	Housekeeping	Patient Days	1,251,572	31	13,578		64,324	698	3
4	05	Utilities	Patient Days	1,251,572	31	30,626		64,324	1,574	4
5	06	Maintenance	Patient Days	1,251,572	31	126,400		64,324	6,496	5
6	17	Administrative	Patient Days	1,251,572	31	84,000		64,324	4,317	6
7	19	Professional Fees	Patient Days	1,251,572	31	239,560		64,324	12,312	7
8	20	Dues and Subscriptions	Patient Days	1,251,572	31	44,626		64,324	2,294	8
9	21	Office and Clerical	Patient Days	1,251,572	31	305,586		64,324	15,705	9
10	24	Seminar and Travel	Patient Days	1,251,572	31	6,989		64,324	359	10
11	25	Other Staff Admin. Trans.	Patient Days	1,251,572	31	34,307		64,324	1,763	11
12	26	Insurance	Patient Days	1,251,572	31	36,877		64,324	1,895	12
13	30	Depreciation	Patient Days	1,251,572	31	113,642		64,324	5,841	13
14	32	Interest	Patient Days	1,251,572	31	26,010		64,324	1,337	14
15	33	Real Estate Taxes	Patient Days	1,251,572	31	66,240		64,324	3,404	15
16	35	Rent - Equipment & Auto	Patient Days	1,251,572	31	20,168		64,324	1,037	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,170,816	$		$ 60,174	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	1,251,572	31	217,811	217,811	64,324	11,194	1
2	06	Maintenance (Direct)	Direct		31	252,781	252,781		1,934	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,251,572	31	20,665		64,324	1,062	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	33,212			243	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,251,572	31	454,189	454,189	64,324	23,343	7
8	21	Office and Clerical (Pooled)	Patient Days	1,251,572	31	2,664,951	2,664,951	64,324	136,964	8
9	21	Office and Clerical (Direct)	Direct		31	385,321	385,321		16,437	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,251,572	31	574,509		64,324	29,527	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	59,282			1,579	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					$ 4,662,721	$ 3,975,053		$ 222,283	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: TriCare Rehab
Street Address: 240 Fencl Lane
City / State / Zip Code: Hillside, IL 60162
Phone Number: (773) 449-9400
Fax Number: (773) 449-9700

	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	10	Rehab	Direct Allocation						279	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					$	$		$ 279	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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			$	$		$ 62,604	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					$	$		$ 62,604	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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: 01/01/14 Ending: 12/31/14

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 ☐

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: 01/01/14 Ending: 12/31/14

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			$	$ 24,821,693			$ 1,187,093	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Note Payable- Computers		X					17,536				6
7												7
8												8
9	TOTAL Facility Related						$	$ 24,839,229			$ 1,187,093	9
	B. Non-Facility Related*											
10	Interest Income - Facility		X								(126)	10
11	Interest Income - Bldg Co.		X								(417)	11
12	Allocated from Extended Care Consulting										1,337	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 794	14
15	TOTALS (line 9+line14)						$	$ 24,839,229			$ 1,187,887	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 124,954 **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.)**

**** 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: 01/01/14 Ending: 12/31/14

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

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8							$	$			$	8
9												9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital											14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											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:** 01/01/14 **Ending:** 12/31/14

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2013 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 265,553	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.)		$ 259,490	2
3. Under or (over) accrual (line 2 minus line 1).		$ (6,063)	3
4. Real Estate Tax accrual used for 2014 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 268,890	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.)**		$ 6,076	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** $ 16,209 **For** 2011 **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.		$ 268,903	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2009	218,307	8
	2010	271,265	9
	2011	262,176	10
	2012	252,907	11
	2013	256,086	12

2014 Accrual = $256,086 x 1.05 = $268,890

Allocated from Extended Care Consulting: $3,404

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2013	$	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.

2013 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 2013 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 2013.

	(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	$ 1,853.46	$ 1,853.46
2.	21-30-112-007-0000	Long Term Care Property	$ 16,201.21	$ 16,201.21
3.	21-30-112-008-0000	Long Term Care Property	$ 18,189.13	$ 18,189.13
4.	21-30-112-011-0000	Long Term Care Property	$ 312.63	$ 312.63
5.	21-30-112-012-0000	Long Term Care Property	$ 312.63	$ 312.63
6.	21-30-112-013-0000	Long Term Care Property	$ 44,643.26	$ 44,643.26
7.	21-30-112-014-0000	Long Term Care Property	$ 56,553.27	$ 56,553.27
8.	21-30-112-017-0000	Long Term Care Property	$ 942.27	$ 942.27
9.	21-30-112-018-0000	Long Term Care Property	$ 948.14	$ 948.14
10.	21-30-112-051-0000	Long Term Care Property	$ 107,254.28	$ 107,254.28
		TOTALS	$ 247,210.28	$ 247,210.28

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 2013 tax bills which were listed in Section A to this statement. Be sure to use the 2013 tax bill which is normally paid during 2014.

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

IMPORTANT NOTICE

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

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

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

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

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 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 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	$ 8,875.86	$ 8,875.86
2.	See Attached	2201 Main Allocation	$ 162,082.08	$ 3,242.30
3.			$	$

4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 170,957.94	$ 12,118.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ 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: 01/01/14 Ending: 12/31/14

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 2201 Main LLC/Care Centers Building LLC			16,403	2
3	TOTALS			$ 501,412	3

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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)	$ 2,448,530	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	39,668		20	1,983	1,983	18,181	9
10	Various			2006	322,466		20	11,998	11,998	187,065	10
11	Various			2007	131,026		20	9,585	9,585	75,007	11
12	Various			2008	248,335		20	11,837	11,837	89,017	12
13	Various			2009	98,114		20	4,874	4,874	36,428	13
14	Various			2010	28,177		20	1,409	1,409	6,202	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: 01/01/14 Ending: 12/31/14

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)		146,293			7,315	7,315	36,573	67
68	Related Party Allocations (Pages 12H & 12I)		72,429	4,565		4,565		49,718	68
69	Financial Statement Depreciation			101,669			(101,669)		69
70	TOTAL (lines 4 thru 69)		$ 10,635,773	$ 352,421		$ 298,419	$ (54,002)	$ 2,946,721	70

**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: 01/01/14 Ending: 12/31/14

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		$ 10,635,773	$ 352,421		$ 298,419	$ (54,002)	$ 2,946,721	1
2	Replace Trane Hot Water Coil	2011	8,680		20	579	579	2,026	2
3	Drain & Duct Work	2011	15,800		20	790	790	2,963	3
4	Painting	2011	6,503		20			6,503	4
5	Replace Outer Coil In Trane Chiller	2011	27,220		20	1,361	1,361	4,764	5
6	New Floor	2011	5,363		20	268	268	916	6
7	Hail Damage	2011	(22,220)		20	(1,111)	(1,111)	(3,796)	7
8	Fire Rated Steel Door	2011	3,550		20	178	178	577	8
9	Install Fire Dampers On 5Th Floor	2011	9,382		20	469	469	1,486	9
10	Fire Rated Steel Door With Window	2011	3,770		20	189	189	628	10
11	Leaking Jack Unit- Elevator	2011	3,350		20	168	168	600	11
12	Masonry Repairs	2012	81,100		20	4,055	4,055	11,489	12
13	Adjust & Repair All Windows In Old Section Of Building	2012	8,870		20	444	444	1,257	13
14	Replace Window Hardware	2012	8,960		20	448	448	1,195	14
15	Window Hardware	2012	7,648		20	382	382	1,020	15
16	Tuckpointing	2012	14,560		20	728	728	1,941	16
17	Window Repairs	2012	44,330		20	2,217	2,217	5,726	17
18	Roof Repair	2012	8,720		20	436	436	981	18
19	Window Repairs	2012	7,900		20	395	395	856	19
20	Thermostat Wiring	2012	2,698		20	135	135	360	20
21	Pump Replacement	2012	3,494		20	175	175	408	21
22	Boiler Repairs	2012	9,500		20	475	475	1,385	22
23	Resurface Parking Lots And Add Parking Stops	2012	22,800		20	1,140	1,140	2,755	23
24	Corridor Smoke Wall - 2Nd, 3Rd, 4Th Floors	2012	52,500		20	2,625	2,625	5,906	24
25	Heating & A/C Rooftop Unit	2012	4,250		20	213	213	478	25
26	Replace Sprinkler Heads	2012	6,842		20	342	342	912	26
27	Install 3 New Dryer Vents	2012	3,510		20	176	176	351	27
28	Geotechnical Investigation	2012	3,975		20	199	199	513	28
29	Replace 112 Window Screens	2012	9,520		20	476	476	1,111	29
30	Replace 16 Thermostats, 16 Adapter Plates & 16 Lock Boxes	2013	6,000		20	1,200	1,200	2,400	30
31	Shower Repair	2013	4,950		20	248	248	495	31
32	Fire Sprinkler System Corrections	2013	11,290		20	565	565	1,129	32
33	Provide & Install Infrared Radiant Heater;Install Sensors/Control	2013	10,300		20	2,060	2,060	4,120	33
34	TOTAL (lines 1 thru 33)		$ 11,030,889	$ 352,421		$ 320,440	$ (31,981)	$ 3,010,175	34

**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: 01/01/14 Ending: 12/31/14

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		$ 11,030,889	$ 352,421		$ 320,440	$ (31,981)	$ 3,010,175	1
2	Manufacture And Install Clear Vinyl Wall Panels	2013	3,994		20	200	200	383	2
3	Emergency Plumbing Repair	2013	9,330		20	467	467	855	3
4	Remove Old Water Coil And Install New One In Kitchen	2013	6,800		20	340	340	595	4
5	Install Horizontal Dry Sidewall Sprinkler Heads On 5 Outside Ove	2013	4,127		20	825	825	1,444	5
6	Furnished & Installed Panic Exit Devices - Exterior & Interior Doo	2013	3,005		20	601	601	952	6
7	Emergency Lights - Fire Pump Room	2013	6,800		20	340	340	510	7
8	Add Outlets - Rms 27-34 & 44-59	2013	10,175		20	509	509	678	8
9	York Roof Top Units	2013	14,000		20	700	700	875	9
10	Rebuild Air Handler On 5Th Floor	2013	2,584		20	129	129	205	10
11	3 L Shaped Nursing Stations	2014	16,500		20	1,925	1,925	1,925	11
12	Chilled Water Pump Assembly	2014	11,483		20	239	239	239	12
13	Installation Of Fire Alarm System	2014	9,086		20	151	151	151	13
14	Generator Repair	2014	4,420		20	37	37	37	14
15	Patient Room Double Window	2014	4,850		20	101	101	101	15
16	Repair Bathroom Ceiling	2014	3,450		20	72	72	72	16
17	3 Door Closers & Front Entrance Doors	2014	15,625		20	260	260	260	17
18	Hot Water Coil	2014	13,519		20	56	56	56	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)		$ 11,170,637	$ 352,421		$ 327,393	$ (25,028)	$ 3,019,514	34

**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: 01/01/14 Ending: 12/31/14

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		$ 11,170,637	$ 352,421		$ 327,393	$ (25,028)	$ 3,019,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,170,637	$ 352,421		$ 327,393	$ (25,028)	$ 3,019,514	34

**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: 01/01/14 Ending: 12/31/14

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		$ 11,170,637	$ 352,421		$ 327,393	$ (25,028)	$ 3,019,514	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,170,637	$ 352,421		$ 327,393	$ (25,028)	$ 3,019,514	34

**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: 01/01/14 Ending: 12/31/14

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 12E, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements								8
9	Remodel bathrooms, showers and doors	2010	84,730		20	4,237	4,237	21,183	9
10	2 Electromagnetic locks	2010	4,175		20	209	209	1,044	10
11	Security camera	2010	2,790		20	140	140	698	11
12	Masonry repairs	2010	10,820		20	541	541	2,705	12
13	Repair glass block	2010	8,700		20	435	435	2,175	13
14	Egress locks and delayed egress locks	2010	21,800		20	1,090	1,090	5,450	14
15	200 Amp electirc sub panel	2010	3,250		20	163	163	813	15
16	Privacy Curtains	2010	10,028		20	501	501	2,507	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)		$ 146,293	$		$ 7,315	$ 7,315	$ 36,573	34

**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: 01/01/14 Ending: 12/31/14

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 12F, Carried Forward		$ 146,293	$		$ 7,315	$ 7,315	$ 36,573	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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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)		$ 146,293	$		$ 7,315	$ 7,315	$ 36,573	34

**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: 01/01/14 Ending: 12/31/14

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 12G, Carried Forward		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 Main LLC/Care Centers Building LLC	2002	22,604	580	20	580		7,124	3
4									4
5									5
6									6
7									7
8	Leasehold Information								8
9	Allocated from Extended Care Consulting LLC	2007	236	12	20	12		95	9
10	Allocated from Extended Care Consulting LLC	2009	141	7	20	7		43	10
11	Allocated from Extended Care Consulting LLC	2010	1387	69	20	69		347	11
12	Allocated from Extended Care Consulting LLC	2011	499	25	20	25		100	12
13	Allocated from Extended Care Consulting LLC	2012	164	8	20	8		25	13
14	Allocated from Extended Care Consulting LLC	2014	2279	114	20	114		114	14
15					20				15
16	Allocated from 2201 Main LLC/Care Centers Building LLC	2002	18,673	1,591	20	1,591		18,673	16
17	Allocated from 2201 Main LLC/Care Centers Building LLC	2003	22,005	1,875	20	1,875		22,005	17
18	Allocated from 2201 Main LLC/Care Centers Building LLC	2005	1,093	116	20	116		975	18
19	Allocated from 2201 Main LLC/Care Centers Building LLC	2009	197	10	20	10		59	19
20	Allocated from 2201 Main LLC/Care Centers Building LLC	2014	3,151	158	20	158		158	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)		$ 72,429	$ 4,565		$ 4,565	$	$ 49,718	34

**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: 01/01/14 Ending: 12/31/14

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 12H, Carried Forward		$ 72,429	$ 4,565		$ 4,565	$	$ 49,718	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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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)		$ 72,429	$ 4,565		$ 4,565	$	$ 49,718	34

**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: 01/01/14 Ending: 12/31/14

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,411,440	$ 633	$ 10,772	$ 10,139	10	$ 1,374,094	71
72	Current Year Purchases	30,564	380	1,157	777	10	1,157	72
73	Fully Depreciated Assets	305,787				10	305,787	73
74								74
75	TOTALS	$ 1,747,791	$ 1,013	$ 11,929	$ 10,916		$ 1,681,038	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 C	2014	$ 9,275	$ 262	$ 262	$	5	$ 8,227	76
77										77
78										78
79										79
80	TOTALS			$ 9,275	$ 262	$ 262	$		$ 8,227	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)	$ 13,429,115	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 353,696	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 339,584	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (14,112)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,708,780	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: 01/01/14 Ending: 12/31/14

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.	/2015	$
13.	/2016	$
14.	/2017	$

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: $ 6,684 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.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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

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

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

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

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

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

B. EXPENSES

ALLOCATION OF COSTS (d)

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

C. CONTRACTUAL INCOME

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

$

D. NUMBER OF CNAs TRAINED

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

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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	N/A	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									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/14 (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	$ 243,678	$ 516,156	1
2	Cash-Patient Deposits	21,442	21,442	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,199,847	1,199,847	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	232,884	371,291	6
7	Other Prepaid Expenses	5,464	5,464	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	52	776,627	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,703,367	$ 2,890,827	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	925,653	2,289,654	15
16	Equipment, at Historical Cost	364,926	364,926	16
17	Accumulated Depreciation (book methods)	(896,081)	(5,178,670)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		280,888	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(41,682)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,503,526	1,503,526	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,898,024	$ 9,365,511	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,601,391	$ 12,256,338	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,740,342	$ 6,740,341	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,491	12,491	28
29	Short-Term Notes Payable	17,536	17,536	29
30	Accrued Salaries Payable	263,416	263,416	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,019	10,019	31
32	Accrued Real Estate Taxes(Sch.IX-B)		268,890	32
33	Accrued Interest Payable		98,253	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	64,551	64,551	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,108,355	$ 7,475,497	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		24,821,693	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,754,103		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,754,103	$ 24,821,693	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,862,458	$ 32,297,190	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,261,067)	$ (20,040,852)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,601,391	$ 12,256,338	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,559,098)	1	
2	Restatements (describe):		2	
3	**Prior year bad debt**	(49,510)	3	
4	**Prior year assessment tax**	98,148	4	
5	**Prior year income / rounding**	4,873	5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,505,587)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(755,480)	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)**	$ (755,480)	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)**	$ (5,261,067)	24	*

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

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

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

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,368,306	1
2	Discounts and Allowances for all Levels	(27,876)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,340,430	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	186,292	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	27,876	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)**	$ 214,168	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	126	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 126	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	560	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 560	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,555,284	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,812,721	31
32	Health Care	3,131,600	32
33	General Administration	2,177,067	33
	B. Capital Expense		
34	Ownership	2,189,315	34
	C. Ancillary Expense		
35	Special Cost Centers	61	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,310,764	40
41	**Income before Income Taxes (line 30 minus line 40)****	(755,480)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (755,480)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,340,430	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 8,340,430	49

* **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.**

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

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

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,878	2,150	$ 98,951	$ 46.02	1
2	Assistant Director of Nursing	2,028	2,123	63,100	29.72	2
3	Registered Nurses	6,977	7,775	216,871	27.89	3
4	Licensed Practical Nurses	32,780	35,469	867,117	24.45	4
5	CNAs & Orderlies	66,172	72,922	791,588	10.86	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,627	2,938	43,956	14.96	9
10	Activity Assistants	11,584	12,649	164,413	13.00	10
11	Social Service Workers	26,156	28,573	558,699	19.55	11
12	Dietician					12
13	Food Service Supervisor	1,990	2,181	46,207	21.19	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,125	6,912	67,166	9.72	15
16	Dishwashers	14,467	16,826	177,171	10.53	16
17	Maintenance Workers	24,430	26,442	333,495	12.61	17
18	Housekeepers	25,070	28,250	268,929	9.52	18
19	Laundry					19
20	Administrator	1,918	2,149	110,417	51.38	20
21	Assistant Administrator	1,658	1,926	61,184	31.77	21
22	Other Administrative					22
23	Office Manager	1,768	2,043	32,592	15.95	23
24	Clerical	5,139	6,152	79,175	12.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	12,861	13,460	145,702	10.82	33
34	TOTAL (lines 1 - 33)	245,628	270,940	$ 4,126,733 *	$ 15.23	34

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

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	353	$ 18,690	01-03	35
36	Medical Director	Monthly	7,200	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	15,231	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				45
46	Other(specify) Dental Consultant	Monthly	250	10-03	46
47	Psychiatrist	Monthly	15,500	10-03	47
48	MDS		2,119	10-03	48
49	TOTAL (lines 35 - 48)	353	$ 58,990		49

C. CONTRACT NURSES

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

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Gully	Administrator	0.00%	$ 110,417
Marlon Holcomb	Assist. Admin.	0.00%	46,657
Gianni Seifer	Assist. Admin.	0.00%	14,527
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 171,601

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
Frost, Ruttenberg & Rothblatt	Accounting	$ 21,050
Extended Care Consulting	Home Office Expense	356,592
Personnel Planners, Inc.	Unemployment Consulting	4,170
Navex Global	Compliance	237
Skidelsky and Associates	Real Estate Tax Objection	220
Pinnacle Quality Insight	Customer Satisfaction	1,265
Bylmas	Tax Credits Consulting	1,707
Hamlin & Burton	Liability Management	994
Legat Architects	Architectural Services	509
Ability Network	Medicare Billing	980
ProPay	Payroll Processing	31,081
See Supplemental Schedule		43,418
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 462,223

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,845
Unemployment Compensation Insurance	146,332
FICA Taxes	310,054
Employee Health Insurance	167,808
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expens	31,021
Holiday Expense	2,813
Other Employee Welfare	4,963
TOTAL (agree to Schedule V, line 22, col.8)	$ 769,836

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	$ 1,990
Advertising: Employee Recruitment	4,815
Health Care Worker Background Check	8,137
(Indicate # of checks performed 312)	
Patient Background Checks	
Dues & Subscriptions	23,789
Licenses & Fees	4,499
Allocated from Extended Care Consulting	2,294
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,524

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,738
Allocated from Extended Care Consulting	359
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,097

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/14 Ending: 12/31/14

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		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/14 **Ending:** 12/31/14

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? **Yes**
If YES, give association name and amount. **Alliance for Living $26,032**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

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

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **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. $
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln 14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

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

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.