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.

2015
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2015)

I. IDPH License ID Number: 0047332

Facility Name: Rainbow Beach Care Center

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

County: Cook

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

HFS ID Number:

Date of Initial License for Current Owners: 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) 282-6300
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 01/01/15 to 12/31/15 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)
(Firm Name & Address) Marcum, LLP, 111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

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: 01/01/15 Ending: 12/31/15

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					10
11	ICF/DD	63,628	61		63,689	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	63,628	61		63,689	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.70%

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

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

Tax Year: 12/31/2015 Fiscal Year: 12/31/2015

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	293,755	37,706	18,953	350,414		350,414	211	350,625			1
2	Food Purchase		336,797		336,797		336,797	558	337,355			2
3	Housekeeping	256,168	63,161		319,329		319,329	1,480	320,809			3
4	Laundry		7,352	59,699	67,051		67,051		67,051			4
5	Heat and Other Utilities			191,444	191,444		191,444	(765)	190,679			5
6	Maintenance	300,474		201,587	502,061		502,061	(11,915)	490,146			6
7	Other (specify):*							1,148	1,148			7
8	**TOTAL General Services**	850,397	445,016	471,683	1,767,096		1,767,096	(9,283)	1,757,813			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,904,667	57,219	33,835	1,995,721		1,995,721	(682)	1,995,039			10
10a	Therapy											10a
11	Activities	197,859	17,540		215,399		215,399		215,399			11
12	Social Services	534,911	41,289		576,200		576,200		576,200			12
13	CNA Training											13
14	Program Transportation			2,198	2,198		2,198		2,198			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,637,437	116,048	43,233	2,796,718		2,796,718	(682)	2,796,036			16
	C. General Administration											
17	Administrative	190,109			190,109		190,109	26,607	216,716			17
18	Directors Fees											18
19	Professional Services			443,427	443,427	(6,530)	436,897	(359,108)	77,789			19
20	Dues, Fees, Subscriptions & Promotions			77,248	77,248		77,248	(34,794)	42,454			20
21	Clerical & General Office Expenses	104,065	24,947	245,896	374,908		374,908	(27,497)	347,411			21
22	Employee Benefits & Payroll Taxes			712,453	712,453		712,453	(4,148)	708,305			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,577	1,577		1,577	454	2,031			24
25	Other Admin. Staff Transportation			21,271	21,271		21,271	1,809	23,080			25
26	Insurance-Prop.Liab.Malpractice			185,540	185,540		185,540	32,582	218,122			26
27	Other (specify):*							28,546	28,546			27
28	**TOTAL General Administration**	294,174	24,947	1,687,412	2,006,533	(6,530)	2,000,003	(335,549)	1,664,454			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,782,008	586,011	2,202,328	6,570,347	(6,530)	6,563,817	(345,515)	6,218,302			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: 01/01/15 Ending: 12/31/15

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			101,403	101,403		101,403	242,008	343,411			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							1,054,207	1,054,207			32
33	Real Estate Taxes			6,994	6,994	6,530	13,524	265,264	278,788			33
34	Rent-Facility & Grounds			2,082,000	2,082,000		2,082,000	(2,082,000)				34
35	Rent-Equipment & Vehicles			5,943	5,943		5,943	1,079	7,022			35
36	Other (specify):*							123,069	123,069			36
37	**TOTAL Ownership**			2,196,340	2,196,340	6,530	2,202,870	(396,373)	1,806,497			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							38	38			39
40	Barber and Beauty Shops			135	135		135		135			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			135	135		135	38	173			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,782,008	586,011	4,398,803	8,766,822		8,766,822	(741,849)	8,024,973			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: 01/01/15 Ending: 12/31/15

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	(3,009)	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	(7,417)	30		9
10	Interest and Other Investment Income	(4,061)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(19,298)	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	(172,590)	21		24
25	Fund Raising, Advertising and Promotional	(3,649)	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	(109,873)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (319,900)		$	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)	(421,949)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (421,949)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (741,849)		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: 01/01/15

Ending: 12/31/15

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medical Records Income	$ (17)	10	1
2	Other Income	(3,097)	21	2
3	Jury Duty	(59)	10	3
4	Patient Clothing	(497)	10	4
5	Theft Loss	(880)	21	5
6	Collection Expense	(2,507)	21	6
7	Building Company - Audit / Bookkeeping	(20,350)	19	7
8	Building Company - Filing Fee	(250)	21	8
9	Building Company - Amortization	(8,025)	36	9
10	Convenience Fee	(132)	21	10
11	Capitalized R&M - Building Company	(18,500)	06	11
12	Capitalized R&M - Facility	(32,743)	06	12
13	PAC Dues	(12,920)	20	13
14	Annual Report	(250)	20	14
15	Non-Allowable Legal	(8,475)	19	15
16	Lobbying Expense	(1,171)	19	16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(109,873)		49

Rainbow Beach Care Center

ID# 0047332

Report Period Beginning: 01/01/15

Ending: 12/31/15

	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			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary			211									211	1
2	Food Purchase	(3)		561									558	2
3	Housekeeping			1,480									1,480	3
4	Laundry													4
5	Heat and Other Utilities	(3,009)		2,244									(765)	5
6	Maintenance	(51,243)	20,000	6,456	12,872								(11,915)	6
7	Other (specify):*				1,148								1,148	7
8	**TOTAL General Services**	(54,255)	20,000	10,952	14,020								(9,283)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(574)					(109)						(682)	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**	(574)					(109)						(682)	16
	C. General Administration													
17	Administrative			4,034	22,573								26,607	17
18	Directors Fees													18
19	Professional Services	(29,996)	20,350	(349,462)									(359,108)	19
20	Fees, Subscriptions & Promotions	(36,117)		1,323									(34,794)	20
21	Clerical & General Office Expenses	(179,455)	250	16,514	135,194								(27,497)	21
22	Employee Benefits & Payroll Taxes				(4,148)								(4,148)	22
23	Inservice Training & Education													23
24	Travel and Seminar			454									454	24
25	Other Admin. Staff Transportation			1,809									1,809	25
26	Insurance-Prop.Liab.Malpractice		30,736	1,846									32,582	26
27	Other (specify):*				28,546								28,546	27
28	**TOTAL General Administration**	(245,568)	51,336	(323,482)	182,165								(335,549)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(300,397)	71,336	(312,530)	196,185		(109)						(345,515)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rainbow Beach Care Center # 0047332 **Report Period Beginning:** 01/01/15 **Ending:** 12/31/15

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	(7,417)	246,500	2,925									242,008	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,061)	1,046,502	11,766									1,054,207	32
33	Real Estate Taxes		259,367	5,897									265,264	33
34	Rent-Facility & Grounds		(2,082,000)										(2,082,000)	34
35	Rent-Equipment & Vehicles			1,079									1,079	35
36	Other (specify):*	(8,025)	131,094										123,069	36
37	**TOTAL Ownership**	(19,503)	(398,537)	21,667									(396,373)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						38						38	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**						38						38	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(319,900)	(327,201)	(290,863)	196,185		(70)						(741,849)	45

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

VII. RELATED PARTIES

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

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

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 2,082,000	Rainbow Beach Real Estate	100.00%	$	$ (2,082,000)	1
2	V	32	Interest	414	Rainbow Beach Real Estate	100.00%	1,046,916	1,046,502	2
3	V	30	Depreciation		Rainbow Beach Real Estate	100.00%	246,500	246,500	3
4	V	19	Audit / Bookkeeping		Rainbow Beach Real Estate	100.00%	20,350	20,350	4
5	V	21	Filing Fee		Rainbow Beach Real Estate	100.00%	250	250	5
6	V	36	Amortization		Rainbow Beach Real Estate	100.00%	8,025	8,025	6
7	V	33	Real Estate Taxes		Rainbow Beach Real Estate	100.00%	259,367	259,367	7
8	V	26	Insurance		Rainbow Beach Real Estate	100.00%	30,736	30,736	8
9	V	06	Repairs and Maintenance		Rainbow Beach Real Estate	100.00%	20,000	20,000	9
10	V	36	Mortgage Insurance Premiums		Rainbow Beach Real Estate	100.00%	123,069	123,069	10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,082,414			$ 1,755,213	$ * (327,201)	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: 01/01/15 Ending: 12/31/15

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%	$ 211	$ 211	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	561	561	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,480	1,480	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	2,244	2,244	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	6,456	6,456	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	4,034	4,034	20
21	V	19	Professional Fees	356,592	Extended Care Consulting, LLC	100.00%	7,130	(349,462)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,323	1,323	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	16,514	16,514	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	454	454	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,809	1,809	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	1,846	1,846	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,925	2,925	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	11,766	11,766	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,897	5,897	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,079	1,079	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			$ 356,592			$ 65,729	$ * (290,863)	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: 01/01/15 Ending: 12/31/15

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%	12,872	$ 12,872	15
16	V	06	Maintenance (Direct)	478	Extended Care Consulting, LLC	100.00%	478		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,108	1,108	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	40	40	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	22,573	22,573	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	135,194	135,194	22
23	V	21	Office and Clerical (Direct)	16,436	Extended Care Consulting, LLC	100.00%	16,436		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	27,083	27,083	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,463	1,463	25
26	V	22	Employee Benefits	4,148	Extended Care Consulting, LLC	100.00%		(4,148)	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			$ 21,062			$ 217,247	$ * 196,185	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: 01/01/15 Ending: 12/31/15

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%	$ 91,475	$ 91,475	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	91,475	CCS Employee Benefits Group	100.00%		(91,475)	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			$ 91,475			$ 91,475	$ *	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: 01/01/15 Ending: 12/31/15

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	Nursing and Medical Records	$ 8,243	MAC Rx, LLC	100.00%	$ 8,134	$ (109)	15
16	V	39	Ancillary	(2,913)	MAC Rx, LLC	100.00%	(2,874)	38	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			$ 5,330			$ 5,260	$ * (70)	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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	51.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	RAINBOW BEACH REAL ESTATE INVESTMENT VENTURE ONE, L		BUILDING CO.	1
2	GALE ROTHNER	49.00%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MANAGEMENT/BOOKKEEP	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING CO.	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	VENTILATOR EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	TRI CARE REHAB	HILLSIDE	THERAPY	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	7
8			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	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			SPRING CREEK NURSING & REHAB CENTER	JOLIET				20
21			ST. JAMES WELLNESS REHAB VILLAS	CRETE				21
22			THE ESTATES OF HYDE PARK	CHICAGO				22
23			THE PARC AT JOLIET	JOLIET				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				25
26			WHEATON CARE CENTER	WHEATON				26
27								27
28								28
29								29
30								30

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	Mark Steinberg	Relative	Administrative	0%	See Attached	3.67	6.67%	Alloc Sal/Fee	$ 13,577	17-7	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.58	1.45%	Alloc. Salary	981	22-7	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	$ 14,558		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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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	1,326,152	31	$ 4,390	$	63,689	$ 211	1
2	02	Food	Patient Days	1,326,152	31	11,689		63,689	561	2
3	03	Housekeeping	Patient Days	1,326,152	31	30,827		63,689	1,480	3
4	05	Utilities	Patient Days	1,326,152	31	46,718		63,689	2,244	4
5	06	Maintenance	Patient Days	1,326,152	31	134,435		63,689	6,456	5
6	17	Administrative	Patient Days	1,326,152	31	84,000		63,689	4,034	6
7	19	Professional Fees	Patient Days	1,326,152	31	148,456		63,689	7,130	7
8	20	Dues and Subscriptions	Patient Days	1,326,152	31	27,539		63,689	1,323	8
9	21	Office and Clerical	Patient Days	1,326,152	31	343,869		63,689	16,514	9
10	24	Seminar and Travel	Patient Days	1,326,152	31	9,455		63,689	454	10
11	25	Other Staff Admin. Trans.	Patient Days	1,326,152	31	37,668		63,689	1,809	11
12	26	Insurance	Patient Days	1,326,152	31	38,431		63,689	1,846	12
13	30	Depreciation	Patient Days	1,326,152	31	60,912		63,689	2,925	13
14	32	Interest	Patient Days	1,326,152	31	244,990		63,689	11,766	14
15	33	Real Estate Taxes	Patient Days	1,326,152	31	122,786		63,689	5,897	15
16	35	Rent - Equipment & Auto	Patient Days	1,326,152	31	22,475		63,689	1,079	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,368,640	$		$ 65,729	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	1,326,152	31	268,019	268,019	63,689	12,872	1
2	06	Maintenance (Direct)	Direct		31	325,218	325,218		478	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,326,152	31	23,065		63,689	1,108	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		31	38,919			40	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,326,152	31	470,018	470,018	63,689	22,573	7
8	21	Office and Clerical (Pooled)	Patient Days	1,326,152	31	2,815,061	2,815,061	63,689	135,194	8
9	21	Office and Clerical (Direct)	Direct		31	402,441	402,441		16,436	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,326,152	31	563,937		63,689	27,083	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		31	58,253			1,463	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					$ 4,964,932	$ 4,280,758		$ 217,247	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			$	$		$ 91,475	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					$	$		$ 91,475	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	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	Nursing And Medical Records	Direct Allocation			$	$		$ 8,134	1
2	39	Ancillary	Direct Allocation						(2,874)	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					$	$		$ 5,260	25

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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
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14										14
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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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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
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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: 01/01/15 Ending: 12/31/15

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			$	$ 24,437,730			$ 1,046,916	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 24,437,730			$ 1,046,916	9
	B. Non-Facility Related*											
10	Interest Income		X								(4,061)	10
11	Interest Income - Bldg. Co.		X								(414)	11
12	Allocated - EC Consulting	X									11,766	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,292	14
15	TOTALS (line 9+line14)						$	$ 24,437,730			$ 1,054,208	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** 123,069 **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: 01/01/15 Ending: 12/31/15

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:** 01/01/15 **Ending:** 12/31/15

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2014 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 268,890	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.)		$ 266,995	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,895)	3
4. Real Estate Tax accrual used for 2015 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 274,153	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.**		$ 6,530	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** $ 10,686 **For** 2012 **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.		$ 278,788	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2010	271,265	8
	2011	262,176	9
	2012	252,907	10
	2013	256,086	11
	2014	261,098	12

2015 Accrual = $261,098 x 1.05 = $261,098

Allocated from Extended Care Consulting = $5,897

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2014	$	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.

2014 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 2014 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 2014.

	(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	$ 1,889.72	$ 1,889.72
2.	21-30-112-007-0000	Long Term Care Property	$ 16,517.86	$ 16,517.86
3.	21-30-112-008-0000	Long Term Care Property	$ 18,544.67	$ 18,544.67
4.	21-30-112-011-0000	Long Term Care Property	$ 318.95	$ 318.95
5.	21-30-112-012-0000	Long Term Care Property	$ 318.95	$ 318.95
6.	21-30-112-013-0000	Long Term Care Property	$ 45,515.81	$ 45,515.81
7.	21-30-112-014-0000	Long Term Care Property	$ 57,658.57	$ 57,658.57
8.	21-30-112-017-0000	Long Term Care Property	$ 961.29	$ 961.29
9.	21-30-112-018-0000	Long Term Care Property	$ 967.21	$ 967.21
10.	21-30-112-051-0000	Long Term Care Property	$ 109,350.62	$ 109,350.62
		TOTALS	$ 252,043.65	$ 252,043.65

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 2014 tax bills which were listed in Section A to this statement. Be sure to use the 2014 tax bill which is normally paid during 2015.

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	$ 9,054.64	$ 9,054.64
2.	See Attached	Allocated from 2201 W. Main	$ 165,913.23	$ 5,576.25
3.	See Attached	Allocated from 502 Main Street	$ 3,814.66	$ 183.20
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 178,782.53	$ 14,814.09

B. **Real Estate Tax Cost Allocations**

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

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

C. **Tax Bills**

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

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			27,560	2
3	TOTALS			$ 512,569	3

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

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	$ 246,500	39	$ 244,853	$ (1,647)	$ 2,693,383	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	39,668		20	1,983	1,983	20,165	9
10	Various			2006	322,466		20	11,998	11,998	199,063	10
11	Various			2007	131,026		20	6,039	6,039	81,046	11
12	Various			2008	248,335		20	11,837	11,837	100,854	12
13	Various			2009	98,114		20	3,874	3,874	40,303	13
14	Various			2010	28,177		20	1,409	1,409	7,611	14
15	Various			2011	61,398		20	2,890	2,890	19,556	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: 01/01/15 Ending: 12/31/15

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)		214,136			10,708	10,708	47,283	67
68	Related Party Allocations (Pages 12H & 12I)		116,497	1,586		1,586		84,468	68
69	Financial Statement Depreciation			101,403			(101,403)		69
70	TOTAL (lines 4 thru 69)		$ 10,809,083	$ 349,489		$ 297,178	$ (52,311)	$ 3,293,731	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: 01/01/15 Ending: 12/31/15

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		$ 10,809,083	$ 349,489		$ 297,178	$ (52,311)	$ 3,293,731	1
2	Masonry Repairs	2012	81,100		20	4,055	4,055	15,544	2
3	Adjust & Repair All Windows In Old Section Of Building	2012	8,870		20	444	444	1,700	3
4	Replace Window Hardware	2012	8,960		20	448	448	1,643	4
5	Window Hardware	2012	7,648		20	382	382	1,402	5
6	Tuckpointing	2012	14,560		20	728	728	2,669	6
7	Window Repairs	2012	44,330		20	2,217	2,217	7,942	7
8	Roof Repair	2012	8,720		20	436	436	1,417	8
9	Window Repairs	2012	7,900		20	395	395	1,251	9
10	Thermostat Wiring	2012	2,698		20	135	135	495	10
11	Pump Replacement	2012	3,494		20	175	175	582	11
12	Boiler Repairs	2012	9,500		20	475	475	1,860	12
13	Resurface Parking Lots And Add Parking Stops	2012	22,800		20	1,140	1,140	3,895	13
14	Corridor Smoke Wall - 2Nd, 3Rd, 4Th Floors	2012	52,500		20	2,625	2,625	8,531	14
15	Heating & A/C Rooftop Unit	2012	4,250		20	213	213	691	15
16	Replace Sprinkler Heads	2012	6,842		20	342	342	1,254	16
17	Geotechnical Investigation	2012	3,975		20	199	199	712	17
18	Replace 112 Window Screens	2012	9,520		20	476	476	1,587	18
19	Install 3 New Dryer Vents	2012	3,510		20	176	176	702	19
20	Replace 16 Thermostats, 16 Adapter Plates & 16 Lock Boxes	2013	6,000		20	1,200	1,200	3,600	20
21	Shower Repair	2013	4,950		20	248	248	743	21
22	Fire Sprinkler System Corrections	2013	11,290		20	565	565	1,694	22
23	Provide & Install Infrared Radiant Heater;Install Sensors/Contro	2013	10,300		20	2,060	2,060	6,180	23
24	Manufacture And Install Clear Vinyl Wall Panels	2013	3,994		20	200	200	582	24
25	Emergency Plumbing Repair	2013	9,330		20	467	467	1,322	25
26	Remove Old Water Coil And Install New One In Kitchen	2013	6,800		20	340	340	935	26
27	Install Horizontal Dry Sidewall Sprinkler Heads On 5 Outside Ov	2013	4,127		20	825	825	2,270	27
28	Furnished & Installed Panic Exit Devices - Exterior & Interior Do	2013	3,005		20	601	601	1,553	28
29	Emergency Lights - Fire Pump Room	2013	6,800		20	340	340	850	29
30	Add Outlets - Rms 27-34 & 44-59	2013	10,175		20	509	509	1,187	30
31	York Roof Top Units	2013	14,000		20	700	700	1,575	31
32	Rebuild Air Handler On 5Th Floor	2013	2,584		20	129	129	334	32
33	3 L Shaped Nursing Stations	2014	16,500		20	3,300	3,300	5,225	33
34	TOTAL (lines 1 thru 33)		$ 11,220,115	$ 349,489		$ 323,719	$ (25,770)	$ 3,375,657	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: 01/01/15 Ending: 12/31/15

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		$ 11,220,115	$ 349,489		$ 323,719	$ (25,770)	$ 3,375,657	1
2	Chilled Water Pump Assembly	2014	11,483		20	574	574	813	2
3	Installation Of Fire Alarm System	2014	9,086		20	454	454	606	3
4	Generator Repair	2014	4,420		20	221	221	258	4
5	Patient Room Double Window	2014	4,850		20	243	243	344	5
6	Repair Bathroom Ceiling	2014	3,450		20	173	173	244	6
7	3 Door Closers & Front Entrance Doors	2014	15,625		20	781	781	1,042	7
8	Hot Water Coil	2014	13,519		20	676	676	732	8
9	Replace Domestic Booster Pump	2015	6,137		20	307	307	307	9
10	Replaced The Motor And Sheave In The Boiler	2015	3,228		20	81	81	81	10
11	Install A Steel Fire Rated Door, Replace 9 Glass Blocks, Caulk Fir	2015	12,000		20	50	50	50	11
12	Installed 4 Shower Drains And 2 Common Drains	2015	3,500		20	175	175	175	12
13	Installed New Relay And Controllers For Damper	2015	6,626		20	331	331	331	13
14	Install New Pump And Soft Starter For Elevator	2015	17,290		20	865	865	865	14
15	Installed Detector Edge In Large Passenger Elevator	2015	2,881		20	144	144	144	15
16	Installed New Pana 40 Door Edge In Passenger Elevator	2015	3,048		20	152	152	152	16
17	Replaced Victalic Seals In #2 Passenger Elevator	2015	2,898		20	145	145	145	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)		$ 11,340,155	$ 349,489		$ 329,090	$ (20,399)	$ 3,381,946	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: 01/01/15 Ending: 12/31/15

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		$ 11,340,155	$ 349,489		$ 329,090	$ (20,399)	$ 3,381,946	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)		$ 11,340,155	$ 349,489		$ 329,090	$ (20,399)	$ 3,381,946	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: 01/01/15 Ending: 12/31/15

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		$ 11,340,155	$ 349,489		$ 329,090	$ (20,399)	$ 3,381,946	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)		$ 11,340,155	$ 349,489		$ 329,090	$ (20,399)	$ 3,381,946	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	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	25,420	9
10	2 Electromagnetic Locks	2010	4,175		20	209	209	1,253	10
11	Security Camera	2010	2,790		20	140	140	838	11
12	Masonry Repairs	2010	10,820		20	541	541	3,246	12
13	Repair Glass Block	2010	8,700		20	435	435	2,610	13
14	Egress Locks and Delayed Egress Locks	2010	21,800		20	1,090	1,090	6,540	14
15	200 Amp Electric Sub Panel	2010	3,250		20	163	163	976	15
16	Privacy Curtains	2010	10,028		20	501	501	3,008	16
17	New Fence	2015	24,500		20	1,225	1,225	1,225	17
18	Installed Floor Tiles in Four Shower Stalls	2015	18,500		20	925	925	925	18
19	IP Office Phone System	2015	24,843		20	1,242	1,242	1,242	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)		$ 214,136	$		$ 10,708	$ 10,708	$ 47,283	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: 01/01/15 Ending: 12/31/15

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		$ 214,136	$		$ 10,708	$ 10,708	$ 47,283	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 214,136	$		$ 10,708	$ 10,708	$ 47,283	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: 01/01/15 Ending: 12/31/15

XI. OWNERSHIP COSTS (continued)

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

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from 2201 Main LLC	2002	37,979	974	39	974		12,944	3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting, LLC	2007	221	11	20	11		99	9
10	Allocated from Extended Care Consulting, LLC	2009	132	7	20	7		46	10
11	Allocated from Extended Care Consulting, LLC	2010	1,296	65	20	65		389	11
12	Allocated from Extended Care Consulting, LLC	2011	466	23	20	23		117	12
13	Allocated from Extended Care Consulting, LLC	2012	154	8	20	8		31	13
14	Allocated from Extended Care Consulting, LLC	2014	2,130	106	20	106		213	14
15									15
16	Allocated from 2201 Main LLC	2002	31,373		20			31,373	16
17	Allocated from 2201 Main LLC	2003	36,972		20			36,972	17
18	Allocated from 2201 Main LLC	2005	1,837	195	20	195		1,834	18
19	Allocated from 2201 Main LLC	2009	331	17	20	17		116	19
20	Allocated from 2201 Main LLC	2014	3,083	154	20	154		308	20
21	Allocated from 2201 Main LLC	2015	523	26	20	26		26	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)		$ 116,497	$ 1,586		$ 1,586	$	$ 84,468	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: 01/01/15 Ending: 12/31/15

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		$ 116,497	$ 1,586		$ 1,586	$	$ 84,468	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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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)		$ 116,497	$ 1,586		$ 1,586	$	$ 84,468	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: 01/01/15 Ending: 12/31/15

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	$ 1,438,116	$ 947	$ 13,929	$ 12,982	10	$ 1,385,715	71
72	Current Year Purchases	1,480	148	148		10	148	72
73	Fully Depreciated Assets	303,717				10	303,717	73
74								74
75	TOTALS	$ 1,743,313	$ 1,095	$ 14,077	$ 12,982		$ 1,689,580	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 EC Consulting, LI	2015	$ 8,667	$ 245	$ 245	$	5	$ 7,933	76
77										77
78										78
79										79
80	TOTALS			$ 8,667	$ 245	$ 245	$		$ 7,933	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)	$ 13,604,705	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 350,829	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 343,412	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,417)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,079,459	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: 01/01/15 Ending: 12/31/15

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.	/2016	$
13.	/2017	$
14.	/2018	$

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: $ 7,022 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: 01/01/15 Ending: 12/31/15

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: 01/01/15 Ending: 12/31/15

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									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:** 01/01/15 **Ending:** 12/31/15

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/15 **(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	$ 248,089	$ 493,231	1
2	Cash-Patient Deposits	33,320	33,320	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	639,084	639,084	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	224,095	361,723	6
7	Other Prepaid Expenses	7,195	7,195	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		805,833	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,151,783	$ 2,340,386	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		9,686,360	14
15	Leasehold Improvements, at Historical Cost	966,125	966,125	15
16	Equipment, at Historical Cost	348,746	1,737,590	16
17	Accumulated Depreciation (book methods)	(996,911)	(5,526,000)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		280,888	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(49,707)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	1,503,526	3,257,629	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,821,486	$ 10,837,894	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,973,269	$ 13,178,280	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,543,669	$ 6,613,013	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,346	17,346	28
29	Short-Term Notes Payable		477,483	29
30	Accrued Salaries Payable	242,033	242,033	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,879	9,879	31
32	Accrued Real Estate Taxes(Sch.IX-B)		274,153	32
33	Accrued Interest Payable		76,368	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	63,972	63,972	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,876,899	$ 7,774,247	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		23,960,247	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule	1,684,761	1,684,761	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,684,761	$ 25,645,008	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,561,660	$ 33,419,255	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,588,391)	$ (20,240,975)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,973,269	$ 13,178,280	48

***(See instructions.)**

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,261,067)	1
2	Restatements (describe):		2
3	Rounding	6	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,261,061)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(527,330)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	200,000	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)**	$ (327,330)	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)**	$ (5,588,391)	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	$ 8,222,733	1
2	Discounts and Allowances for all Levels	(7,905)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,214,828	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	6,744	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)**	$ 6,744	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,061	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,061	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	13,859	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,859	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,239,492	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,767,096	31
32	Health Care	2,796,718	32
33	General Administration	2,006,533	33
	B. Capital Expense		
34	Ownership	2,196,340	34
	C. Ancillary Expense		
35	Special Cost Centers	135	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)***	$ 8,766,822	40
41	**Income before Income Taxes (line 30 minus line 40)****	(527,330)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (527,330)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,205,068	44
45	Private Pay - Net Inpatient Revenue	9,760	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)	$ 8,214,828	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	1,838	2,108	$ 97,305	$ 46.16	1
2	Assistant Director of Nursing	432	422	12,686	30.06	2
3	Registered Nurses	7,736	8,730	251,600	28.82	3
4	Licensed Practical Nurses	25,448	27,326	678,344	24.82	4
5	CNAs & Orderlies	62,328	70,113	763,672	10.89	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,945	4,330	63,216	14.60	9
10	Activity Assistants	10,130	11,273	134,643	11.94	10
11	Social Service Workers	24,515	27,020	512,101	18.95	11
12	Dietician	334	402	5,039	12.53	12
13	Food Service Supervisor	2,003	2,148	42,679	19.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	5,232	5,864	60,049	10.24	15
16	Dishwashers	15,497	17,974	185,988	10.35	16
17	Maintenance Workers	21,297	23,335	300,474	12.88	17
18	Housekeepers	23,458	25,486	256,168	10.05	18
19	Laundry					19
20	Administrator	1,924	2,161	112,551	52.08	20
21	Assistant Administrator	1,920	2,123	77,558	36.53	21
22	Other Administrative					22
23	Office Manager	1,805	2,106	33,521	15.92	23
24	Clerical	5,283	6,032	70,544	11.69	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	10,680	11,707	123,871	10.58	33
34	TOTAL (lines 1 - 33)	225,805	250,660	$ 3,782,009 *	$ 15.09	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	355	$ 18,953	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	12,835	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)				46
47	Phsychiatrist Consultant	Monthly	21,000	10 - 03	47
48					48
49	TOTAL (lines 35 - 48)	355	$ 59,988		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	$ 112,551
Gianni Seifer	Asst. Admin	0	77,558
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 190,109

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
Pro Payroll Solutions	Payroll Processing	$ 27,827
National Datacare Corporation	Resident Fund Processing	5,667
Extended Care Consulting	Home Office Expense	356,592
FRR / Marcum	Accounting	22,548
Personnel Planners	Unemployment Consulting	2,741
Online MSDS	MSDS Management	642
The William Everett Group	IT Consulting	160
S4 Group	Lobbying	1,171
Pinnacle Quality Insight	Customer Satisfaction	990
Legat Architects	Architectural Services	3,614
Hamlin & Burton	Liability Management	2,002
See Supplemental Schedule		19,472
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 443,427

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 104,604
Unemployment Compensation Insurance	97,885
FICA Taxes	289,324
Employee Health Insurance	176,693
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	323
Pension Expense	33,744
Other Employee Benefits	4,583
Holiday Expense	1,150
TOTAL (agree to Schedule V, line 22, col.8)	$ 708,305

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	8,950
Health Care Worker Background Check	
(Indicate # of checks performed 72)	3,796
Patient Background Checks	
Dues and Subscriptions	25,437
Licenses and Fees	958
Allocated from Extended Care Consulting	1,323
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 42,454

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,578
Allocated from Extended Care Consulting	454
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,032

**See instructions.

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/15 Ending: 12/31/15

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:** 01/01/15 **Ending:** 12/31/15

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 $27,372**

(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 **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $
This amount is to be recorded on line 42 of Schedule V.

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

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

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

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

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

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

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

(19) 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.