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.

2017
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2017)

I. IDPH License ID Number: 0054247

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: Steven N. 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 01/01/17 to 12/31/17 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)
** Subject to the attached Accountants' Consulting Report*
(Date)
(Print Name and Title)
(Firm Name & Address) Marcum, LLP, 9 Parkway North, Suite 200 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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

III. STATISTICAL DATA

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

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	211	Intermediate (ICF)	211	77,015	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,015	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	60,848	150		60,998	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	60,848	150		60,998	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.20%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/2005 NO [ ]

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

Medicare Intermediary ____

IV. ACCOUNTING BASIS

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

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

Tax Year: 12/31/17 Fiscal Year: 12/31/17

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	320,896	45,192	15,526	381,614		381,614	225	381,839			1
2	Food Purchase		361,460		361,460		361,460	648	362,108			2
3	Housekeeping	264,833	67,885		332,718		332,718	1,359	334,077			3
4	Laundry		5,181	44,981	50,162		50,162		50,162			4
5	Heat and Other Utilities			179,740	179,740		179,740	1,684	181,424			5
6	Maintenance	235,259	(27)	222,709	457,941		457,941	(33,609)	424,332			6
7	Other (specify):*							923	923			7
8	TOTAL General Services	820,988	479,691	462,956	1,763,635		1,763,635	(28,770)	1,734,865			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,960,015	32,490	51,407	2,043,912		2,043,912	(2,490)	2,041,422			10
10a	Therapy	360			360		360		360			10a
11	Activities	215,983	20,846		236,829		236,829		236,829			11
12	Social Services	597,093	37,690		634,783		634,783		634,783			12
13	CNA Training											13
14	Program Transportation			175	175		175		175			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,773,451	91,026	58,782	2,923,259		2,923,259	(2,490)	2,920,769			16
	C. General Administration											
17	Administrative	115,637			115,637		115,637	23,424	139,061			17
18	Directors Fees											18
19	Professional Services			465,261	465,261	(250)	465,011	(366,962)	98,049			19
20	Dues, Fees, Subscriptions & Promotions			91,684	91,684		91,684	(31,072)	60,612			20
21	Clerical & General Office Expenses	153,501	27,263	447,767	628,531		628,531	(263,910)	364,621			21
22	Employee Benefits & Payroll Taxes			745,781	745,781		745,781	(5,847)	739,934			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,897	2,897		2,897	43	2,940			24
25	Other Admin. Staff Transportation			18,932	18,932		18,932	1,125	20,057			25
26	Insurance-Prop.Liab.Malpractice			185,733	185,733		185,733	31,590	217,323			26
27	Other (specify):*							29,759	29,759			27
28	TOTAL General Administration	269,138	27,263	1,958,055	2,254,456	(250)	2,254,206	(581,850)	1,672,356			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,863,577	597,980	2,479,793	6,941,350	(250)	6,941,100	(613,110)	6,327,990			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 #0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			79,792	79,792		79,792	300,220	380,012			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			579	579		579	885,913	886,492			32
33	Real Estate Taxes					250	250	316,138	316,388			33
34	Rent-Facility & Grounds			2,082,000	2,082,000		2,082,000	(2,082,000)				34
35	Rent-Equipment & Vehicles			13,042	13,042		13,042	1,243	14,285			35
36	Other (specify):*			150,353	150,353		150,353	(43,881)	106,472			36
37	**TOTAL Ownership**			2,325,766	2,325,766	250	2,326,016	(622,367)	1,703,649			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**											44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,863,577	597,980	4,805,559	9,267,116		9,267,116	(1,235,477)	8,031,639			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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	297,334	30		9
10	Interest and Other Investment Income	(20,350)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(9)	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	(10,000)	21		18
19	Entertainment				19
20	Contributions	(16,940)	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	(384,308)	21		24
25	Fund Raising, Advertising and Promotional	(3,449)	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	(257,900)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (395,622)		$	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)	(839,855)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (839,855)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,235,477)		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# 0054247

Report Period Beginning: 01/01/17

Ending: 12/31/17

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (527)	10	1
2	Theft Loss	(1,900)	21	2
3	Collection Expense	(2,448)	21	3
4	Amortization	(150,353)	36	4
5	Alliance for Living - Lobbying	(11,441)	20	5
6	Other Income	(29)	21	6
7	Non-Allowable Legal Fees	(11,715)	19	7
8	Capitalized R&M	(48,196)	06	8
9	Annual Report	(250)	20	9
10	Building Company - Management Fee	(10,550)	19	10
11	Building Company - Audit Fee	(8,900)	19	11
12	Building Company - Filing Fee	(250)	21	12
13	Building Company - Amortization Expense	(8,025)	36	13
14	Lobbying Expense	(3,184)	19	14
15	Convenience Fee	(132)	33	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(257,900)		49

Rainbow Beach Care Center

ID# 0054247

Report Period Beginning: 01/01/17

Ending: 12/31/17

	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 # 0054247 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary			225									225	1
2	Food Purchase	(9)		657									648	2
3	Housekeeping			1,359									1,359	3
4	Laundry													4
5	Heat and Other Utilities			1,684									1,684	5
6	Maintenance	(48,196)		4,637	9,950								(33,609)	6
7	Other (specify):*				923								923	7
8	**TOTAL General Services**	(48,205)		8,562	10,873								(28,770)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(527)				(1,963)							(2,490)	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**	(527)				(1,963)							(2,490)	16
	C. General Administration													
17	Administrative			3,470	19,954								23,424	17
18	Directors Fees													18
19	Professional Services	(34,349)	19,450	(352,131)		68							(366,962)	19
20	Fees, Subscriptions & Promotions	(32,080)		1,008									(31,072)	20
21	Clerical & General Office Expenses	(398,935)	250	9,972	124,803								(263,910)	21
22	Employee Benefits & Payroll Taxes				(5,847)								(5,847)	22
23	Inservice Training & Education													23
24	Travel and Seminar			43									43	24
25	Other Admin. Staff Transportation			1,125									1,125	25
26	Insurance-Prop.Liab.Malpractice		29,560	2,030									31,590	26
27	Other (specify):*				29,759								29,759	27
28	**TOTAL General Administration**	(465,364)	49,260	(334,483)	168,669	68							(581,850)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(514,096)	49,260	(325,921)	179,542	(1,895)							(613,110)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rainbow Beach Care Center # 0054247 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	297,334		2,886									300,220	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(20,350)	888,188	18,075									885,913	32
33	Real Estate Taxes	(132)	311,198	5,072									316,138	33
34	Rent-Facility & Grounds		(2,082,000)										(2,082,000)	34
35	Rent-Equipment & Vehicles			1,243									1,243	35
36	Other (specify):*	(158,378)	114,497										(43,881)	36
37	TOTAL Ownership	118,474	(768,117)	27,276									(622,367)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(395,622)	(718,857)	(298,645)	179,542	(1,895)							(1,235,477)	45

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Income	310	Rainbow Beach Real Estate	100.00%		(310)	2
3	V	19	Management Fee		Rainbow Beach Real Estate	100.00%	10,550	10,550	3
4	V	19	Audit Fee		Rainbow Beach Real Estate	100.00%	8,900	8,900	4
5	V	21	Filing Fee		Rainbow Beach Real Estate	100.00%	250	250	5
6	V	36	Amortization Expense		Rainbow Beach Real Estate	100.00%	8,025	8,025	6
7	V	33	Real Estate Tax Expenses		Rainbow Beach Real Estate	100.00%	311,198	311,198	7
8	V	26	Insurance		Rainbow Beach Real Estate	100.00%	29,560	29,560	8
9	V	32	Interest Expense - HUD		Rainbow Beach Real Estate	100.00%	888,498	888,498	9
10	V	36	Mortgage Insurance Premium		Rainbow Beach Real Estate	100.00%	106,472	106,472	10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,082,310			$ 1,363,453	$ * (718,857)	14

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 225	$ 225	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	657	657	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,359	1,359	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,684	1,684	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	4,637	4,637	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,470	3,470	20
21	V	19	Professional Fees	356,592	Extended Care Consulting, LLC	100.00%	4,461	(352,131)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,008	1,008	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	9,972	9,972	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	43	43	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,125	1,125	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,030	2,030	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	2,886	2,886	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	18,075	18,075	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,072	5,072	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,243	1,243	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			$ 57,947	$ * (298,645)	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	9,950	$ 9,950	15
16	V	06	Maintenance (Direct)		Extended Care Consulting, LLC	100.00%			16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	923	923	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%			18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	19,954	19,954	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	124,803	124,803	22
23	V	21	Office and Clerical (Direct)	19,490	Extended Care Consulting, LLC	100.00%	19,490		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	27,970	27,970	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	1,789	1,789	25
26	V	22	Employee Benefits	5,847	Extended Care Consulting, LLC	100.00%		(5,847)	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			$ 25,337			$ 204,879	$ * 179,542	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	23,759	MAC Rx, LLC	100.00%	21,797	(1,963)	15
16	V	10A	Therapy		MAC Rx, LLC	100.00%			16
17	V	19	Professional Services	(818)	MAC Rx, LLC	100.00%	(751)	68	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 22,941			$ 21,046	$ * (1,895)	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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%	$ 178,368	$ 178,368	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	178,368	CCS Employee Benefits Group	100.00%		(178,368)	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			$ 178,368			$ 178,368	$ *	39

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 ESTAT	CHICAGO	BUILDING COMPANY	1
2	GALE ROTHNER	49.00%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	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 COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLY	DES PLAINES	MEDICAL SUPPLIES	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			LITTLE VILLAGE NURSING & REHABILITATION CENTER, L.L.C.	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			SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	3.43	6.24%	Alloc Sal/Fee	$ 12,468	17-7	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.79	1.98%	Alloc Salary	1,371	21-7	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	$ 13,839		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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	$ 5,451	$	60,998	$ 225	1
2	02	Food	Patient Days	1,476,506	37	15,903		60,998	657	2
3	03	Housekeeping	Patient Days	1,476,506	37	32,901		60,998	1,359	3
4	05	Utilities	Patient Days	1,476,506	37	40,755		60,998	1,684	4
5	06	Maintenance	Patient Days	1,476,506	37	112,249		60,998	4,637	5
6	17	Administrative	Patient Days	1,476,506	37	84,000		60,998	3,470	6
7	19	Professional Fees	Patient Days	1,476,506	37	107,994		60,998	4,461	7
8	20	Dues and Subscriptions	Patient Days	1,476,506	37	24,409		60,998	1,008	8
9	21	Office and Clerical	Patient Days	1,476,506	37	241,371		60,998	9,972	9
10	24	Seminar and Travel	Patient Days	1,476,506	37	1,048		60,998	43	10
11	25	Other Staff Admin. Trans.	Patient Days	1,476,506	37	27,239		60,998	1,125	11
12	26	Insurance	Patient Days	1,476,506	37	49,139		60,998	2,030	12
13	30	Depreciation	Patient Days	1,476,506	37	69,861		60,998	2,886	13
14	32	Interest	Patient Days	1,476,506	37	437,528		60,998	18,075	14
15	33	Real Estate Taxes	Patient Days	1,476,506	37	122,769		60,998	5,072	15
16	35	Rent - Equipment & Auto	Patient Days	1,476,506	37	30,092		60,998	1,243	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,402,709	$		$ 57,947	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	1,476,506	37	240,841	240,841	60,998	9,950	1
2	06	Maintenance (Direct)	Direct		21	358,056	358,056			2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,476,506	37	22,330		60,998	923	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		21	51,193				4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,476,506	37	483,002	483,002	60,998	19,954	7
8	21	Office and Clerical (Pooled)	Patient Days	1,476,506	37	3,020,951	3,020,951	60,998	124,803	8
9	21	Office and Clerical (Direct)	Direct		28	498,631	498,631		19,490	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,476,506	37	677,040		60,998	27,970	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	74,203			1,789	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					$ 5,426,248	$ 4,601,481		$ 204,879	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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						21,797	1
2	10A	Therapy	Direct Allocation							2
3	19	Professional Services	Direct Allocation						(751)	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					$	$		$ 21,046	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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			$	$		$ 178,368	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					$	$		$ 178,368	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HUD		X	Mortgage			$	$ 23,464,547			$ 888,498	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Allocated from Extended Care Consulting										18,075	6
7												7
8												8
9	TOTAL Facility Related						$	$ 23,464,547			$ 906,573	9
	B. Non-Facility Related*											
10	Interest Income		X								(20,350)	10
11	Other Interest Expense		X								579	11
12	Interest Income - Bldg Co	X									(310)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (20,081)	14
15	TOTALS (line 9+line14)						$	$ 23,464,547			$ 886,492	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 106,472 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 **#** 0054247 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2016 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 279,020	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.)		$ 292,919	2
3. Under or (over) accrual (line 2 minus line 1).		$ 13,899	3
4. Real Estate Tax accrual used for 2017 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 302,239	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.)		$ 250	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 316,388	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2012	252,907	8
	2013	256,086	9
	2014	261,098	10
	2015	265,733	11
	2016	287,847	12

2017 Accrual = $ 287,847 x 1.05 = $302,239 (Rounded)

Allocated from Extended Care Consulting - $5,072

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2016	$	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.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rainbow Beach Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054247

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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	$ 1,998.19	$ 1,998.19
2.	21-30-112-007-0000	Long Term Care Property	$ 18,229.03	$ 18,229.03
3.	21-30-112-008-0000	Long Term Care Property	$ 20,467.42	$ 20,467.42
4.	21-30-112-011-0000	Long Term Care Property	$ 353.11	$ 353.11
5.	21-30-112-012-0000	Long Term Care Property	$ 353.11	$ 353.11
6.	21-30-112-013-0000	Long Term Care Property	$ 50,228.50	$ 50,228.50
7.	21-30-112-014-0000	Long Term Care Property	$ 63,637.59	$ 63,637.59
8.	21-30-112-017-0000	Long Term Care Property	$ 1,065.11	$ 1,065.11
9.	21-30-112-018-0000	Long Term Care Property	$ 1,071.54	$ 1,071.54
10.	21-30-112-051-0000	Long Term Care Property	$ 120,413.07	$ 120,413.07
		TOTALS	$ 277,816.67	$ 277,816.67

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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: 2016 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 2016 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2016.

Please complete the Real Estate Tax Statement below and include it in the 2017 cost report along with a copy of your 2016 real estate tax bill.

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 Bureau of Health Finance at (217) 782-1630.

2016 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rainbow Beach Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054247

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 282-6300 FAX #: (847) 282-6301

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

Enter the tax index number and real estate tax assessed for 2016 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 2016.

	(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 Facility	$ 10,030.44	$ 10,030.44
2.	See Attached	Allocated from 2201 W Main St. Bld	$ 181,041.00	$ 5,071.88
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 191,071.44	$ 15,102.32

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 2016 tax bills which were listed in Section A to this statement. Be sure to use the 2016 tax bill which is normally paid during 2017.

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Care Center Building			22,972	2
3	TOTALS			$ 507,981	3

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$	39	$ 244,853	$ 244,853	$ 3,183,089	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	39,668		20	1,983	1,983	24,131	9
10	Various			2006	322,466		20	11,998	11,998	223,058	10
11	Various			2007	131,026		20	5,833	5,833	92,918	11
12	Various			2008	248,335		20	11,837	11,837	124,529	12
13	Various			2009	98,114		20	3,874	3,874	48,052	13
14	Various			2010	28,177		20	1,409	1,409	10,428	14
15	Various			2011	61,398		20	2,890	2,890	25,335	15
16	Various			2012	301,177		20	15,059	15,059	83,996	16
17	Various			2013	93,355		20	8,183	8,183	39,189	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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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)		455,996			22,801	22,801	92,885	67
68	Related Party Allocations (Pages 12H & 12I)		114,123	1,737		1,737		75,704	68
69	Financial Statement Depreciation			79,792			(79,792)		69
70	TOTAL (lines 4 thru 69)		$ 11,443,101	$ 81,529		$ 332,457	$ 250,928	$ 4,023,314	70

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 11,443,101	$ 81,529		$ 332,457	$ 250,928	$ 4,023,314	1
2	3 L Shaped Nursing Stations	2014	16,500		20	3,300	3,300	11,825	2
3	Chilled Water Pump Assembly	2014	11,483		20	574	574	1,962	3
4	Installation Of Fire Alarm System	2014	9,086		20	454	454	1,514	4
5	Generator Repair	2014	4,420		20	221	221	700	5
6	Patient Room Double Window	2014	4,850		20	243	243	829	6
7	Repair Bathroom Ceiling	2014	3,450		20	173	173	589	7
8	3 Door Closers & Front Entrance Doors	2014	15,625		20	781	781	2,604	8
9	Hot Water Coil	2014	13,519		20	676	676	2,084	9
10	Replace Domestic Booster Pump	2015	6,137		20	307	307	921	10
11	Replace Motor And Sheave In Boiler	2015	3,228		20	161	161	404	11
12	Install Steel Fire Rated Door, Replace 9 Glass Blocks, Caulk 1St F	2015	12,000		20	600	600	1,250	12
13	Install 4 Shower Drains & 2 Common Drains	2015	3,500		20	175	175	438	13
14	Install New Relay & Controller For Damper	2015	6,626		20	331	331	690	14
15	Install New Pump & Soft Starter For Elevator	2015	17,290		20	865	865	2,377	15
16	Install Detector Edge In Large Passenger Elevator	2015	2,881		20	144	144	396	16
17	Install New Pana 40 Door Edge In Passenger Elevator	2015	3,048		20	152	152	368	17
18	Replace Victalic Seals In # 2 Passenger Elevator	2015	2,898		20	145	145	350	18
19	Boiler Repair	2016	5,454		20	273	273	545	19
20	Sewer Repair	2016	4,500		20	225	225	375	20
21	Sewer Repair	2016	7,150		20	358	358	447	21
22	Sewer Repair	2016	7,600		20	380	380	475	22
23	Concrete Walk Way	2016	5,500		20	275	275	298	23
24	Replaced Defective Safety Edge Passenger Elevator	2016	2,629		20	131	131	208	24
25	Replaced Passenger Elevator Main Line, Replaced Door Board	2016	2,619		20	131	131	153	25
26	Replaced Packing On North Passenger Elevator	2016	4,585		20	229	229	439	26
27	Fire Alarm System - New Annuciators For Floors 1-5	2017	6,089		20	304	304	304	27
28	Southwest Cafeteria Fire Exit Door	2017	10,350		20	1,725	1,725	1,725	28
29	2Nd Floor Bathroom Remodel-New Showers, Floor & Wall Tile	2017	9,060		20	340	340	340	29
30	Masonry Tuck Pointing- Back Of Building	2017	40,000		20	1,500	1,500	1,500	30
31	1St Flr Bathroom-New Concrete Floors/Plumbing,Wall/Floor Tile	2017	14,990		20	500	500	500	31
32	2Nd Floor Bathroom - New Showers, Drains, Walls	2017	7,700		20	257	257	257	32
33	1St Floor Bathroom- New Floor Tile, Repair & Paint Walls	2017	3,850		20	128	128	128	33
34	TOTAL (lines 1 thru 33)		$ 11,711,718	$ 81,529		$ 348,515	$ 266,986	$ 4,060,309	34

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 11,711,718	$ 81,529		$ 348,515	$ 266,986	$ 4,060,309	1
2	Masonry Tuck Pointing - Back Of Building	2017	48,000		20	1,400	1,400	1,400	2
3	Electrical Work-Offices, Kitchen, Remove Exhaust Fan	2017	4,190		20	122	122	122	3
4	Duct Work Replacement And New Air Conditioners	2017	37,266		20	3,727	3,727	3,727	4
5	Magnetic Locks On 1St Floor	2017	3,852		20	80	80	80	5
6	Masonry Tuck Pointing	2017	48,000		20	1,000	1,000	1,000	6
7	New Exterior Door And Masonry	2017	10,000		20	167	167	167	7
8	Hvac Roof Top Exhaust Fan Replacement	2017	3,000		20	50	50	50	8
9	5Th Floor Roof Coating	2017	4,900		20	61	61	61	9
10	1St Floor Roof Coating	2017	13,050		20	163	163	163	10
11	1St Floor Roof Coating	2017	3,500		20	44	44	44	11
12	Masonry Tuck Pointing - Back Of Building	2017	48,000		20	400	400	400	12
13	Repack Cylinder Heads On Elevator	2017	3,450		20	173	173	173	13
14	Replaced Pump Motor On Elevator	2017	7,495		20	375	375	375	14
15	Install New Door Board In Large Elevator	2017	3,270		20	164	164	164	15
16	Install New Door Board In Elevator #1	2017	4,941		20	247	247	247	16
17	Install New Selector Board In Elevator #1	2017	7,788		20	389	389	389	17
18	Install New Car Board In Big Passenger Elevator	2017	5,550		20	278	278	278	18
19	Install New Clc Board In Large Passenger Elevator	2017	2,855		20	143	143	143	19
20	Elevator Maintence On Both Elevators	2017	4,267		20	213	213	213	20
21	Install New Clc Board In Large Passenger Elevator	2017	3,307		20	165	165	165	21
22	Repair Wiring On P24C Circuit In Large Passenger Elevator	2017	2,501		20	125	125	125	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)		$ 11,980,900	$ 81,529		$ 358,000	$ 276,471	$ 4,069,794	34

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 11,980,900	$ 81,529		$ 358,000	$ 276,471	$ 4,069,794	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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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)		$ 11,980,900	$ 81,529		$ 358,000	$ 276,471	$ 4,069,794	34

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 11,980,900	$ 81,529		$ 358,000	$ 276,471	$ 4,069,794	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,980,900	$ 81,529		$ 358,000	$ 276,471	$ 4,069,794	34

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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									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	33,894	9
10	2 Electromagnetic Locks	2010	4,175		20	209	209	1,671	10
11	Security Camera	2010	2,790		20	140	140	1,118	11
12	Masonry Repairs	2010	10,820		20	541	541	4,328	12
13	Repair Glass Block	2010	8,700		20	435	435	3,480	13
14	Egress Locks and Delayed Egress Locks	2010	21,800		20	1,090	1,090	8,720	14
15	200 Amp Electric Sub Panel	2010	3,250		20	163	163	1,302	15
16	Privacy Curtains	2010	10,028		20	501	501	4,010	16
17	New Fence	2015	24,500		20	1,225	1,225	3,675	17
18	Installed Floor Tiles in Four Shower Stalls	2015	18,500		20	925	925	2,775	18
19	IP Office Phone System	2015	24,843		20	1,242	1,242	3,726	19
20	Roof Repairs	2016	190,560		20	9,528	9,528	19,056	20
21	1st Flr Bathroom-new concrete floors, shower wall/floor tile, caulk	2016	9,500		20	475	475	950	21
22	Waterproof Membrane	2016	17,000		20	850	850	1,700	22
23	Fence Painting	2016	9,800		20	490	490	980	23
24	Hot Water Tank	2016	15,000		20	750	750	1,500	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)		$ 455,996	$		$ 22,801	$ 22,801	$ 92,885	34

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 455,996	$		$ 22,801	$	$ 92,885	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 455,996	$		$ 22,801	$	$ 92,885	34

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 Extended Care Consulting-Care Center Bldg	2002	31,657	812	39	812		12,412	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	9,915	220	45	220		2,306	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting	2007	190	10	20	10		105	9
10	Allocated from Extended Care Consulting	2009	114	6	20	6		51	10
11	Allocated from Extended Care Consulting	2010	1,115	56	20	56		446	11
12	Allocated from Extended Care Consulting	2011	401	20	20	20		141	12
13	Allocated from Extended Care Consulting	2012	132	7	20	7		40	13
14	Allocated from Extended Care Consulting	2014	1,832	92	20	92		367	14
15	Allocated from Extended Care Consulting	2016	2,197	110	20	110		220	15
16									16
17	Allocated from Extended Care Consulting-Care Center Bldg	2002	26,151		20			26,151	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2003	30,818		20			30,818	18
19	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,531		20			1,531	19
20	Allocated from Extended Care Consulting-Care Center Bldg	2009	276	14	20	14		124	20
21	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,652	133	20	133		530	21
22	Allocated from Extended Care Consulting-Care Center Bldg	2015	436	22	20	22		141	22
23	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,721	86	20	86		172	23
24	Allocated from Extended Care Consulting-Care Center Bldg	2017	2,985	149	20	149		149	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)		$ 114,123	$ 1,737		$ 1,737	$	$ 75,704	34

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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		$ 114,123	$ 1,737		$ 1,737	$	$ 75,704	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 114,123	$ 1,737		$ 1,737	$	$ 75,704	34

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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	$ 54,835	$ 942	$ 7,750	$ 6,808	10	$ 35,768	71
72	Current Year Purchases	2,772		277	277	10	277	72
73	Fully Depreciated Assets	1,666,170		13,778	13,778	10	1,666,170	73
74								74
75	TOTALS	$ 1,723,778	$ 942	$ 21,805	$ 20,863		$ 1,702,215	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Consulting		$ 7,456	$ 211	$ 211	$	5	$ 7,245	76
77										77
78										78
79										79
80	TOTALS			$ 7,456	$ 211	$ 211	$		$ 7,245	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)	$ 14,220,115	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 82,682	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 380,016	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 297,334	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 5,779,254	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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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.	/2018	$
13.	/2019	$
14.	/2020	$

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: $ 14,285 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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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 # 0054247 Report Period Beginning: 01/01/17 Ending: 12/31/17

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):									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 **#** 0054247 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/17 **(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	$ 119,957	$ 387,185	1
2	Cash-Patient Deposits	29,331	29,331	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	564,255	564,255	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	73,987	214,271	6
7	Other Prepaid Expenses	7,244	7,244	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		684,229	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 794,774	$ 1,886,515	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		9,917,320	14
15	Leasehold Improvements, at Historical Cost	1,305,626	1,305,626	15
16	Equipment, at Historical Cost	351,746	1,755,590	16
17	Accumulated Depreciation (book methods)	(1,158,630)	(5,954,365)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,202,820	1,417,951	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,701,562	$ 8,927,131	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,496,336	$ 10,813,646	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,502,282	$ 7,748,180	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	15,260	15,260	28
29	Short-Term Notes Payable		514,611	29
30	Accrued Salaries Payable	280,878	280,878	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,191	12,191	31
32	Accrued Real Estate Taxes(Sch.IX-B)		302,239	32
33	Accrued Interest Payable		73,327	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	17,134	17,134	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 9,827,745	$ 8,963,820	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		22,949,936	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		1,062,398	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 24,012,334	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 9,827,745	$ 32,976,154	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,331,409)	$ (22,162,508)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,496,336	$ 10,813,646	48

***(See instructions.)**

Facility Name & ID Number Rainbow Beach Care Center **#** 0054247 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (6,417,422)	1
2	Restatements (describe):		2
3	Rounding	11	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (6,417,411)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,063,998)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	150,000	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)**	$ (913,998)	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)**	$ (7,331,409)	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	$ 8,184,383	1
2	Discounts and Allowances for all Levels	(4,760)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,179,623	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	3,116	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)**	$ 3,116	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	20,350	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,350	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	29	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 29	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,203,118	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,763,635	31
32	Health Care	2,923,259	32
33	General Administration	2,254,456	33
	B. Capital Expense		
34	Ownership	2,325,766	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,267,116	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,063,998)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,063,998)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,154,123	44
45	Private Pay - Net Inpatient Revenue	25,500	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)	$ 8,179,623	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	1,901	2,147	$ 95,966	$ 44.70	1
2	Assistant Director of Nursing	1,621	1,817	64,804	35.67	2
3	Registered Nurses	6,353	6,901	209,772	30.40	3
4	Licensed Practical Nurses	21,031	22,959	639,496	27.85	4
5	CNAs & Orderlies	57,830	63,599	806,577	12.68	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	30	30	360	12.00	8
9	Activity Director	3,789	4,171	63,423	15.21	9
10	Activity Assistants	10,813	11,594	152,560	13.16	10
11	Social Service Workers	26,241	28,800	575,240	19.97	11
12	Dietician	1,780	1,959	25,452	12.99	12
13	Food Service Supervisor	1,925	2,139	48,823	22.83	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,391	4,591	56,282	12.26	15
16	Dishwashers	14,621	16,222	190,339	11.73	16
17	Maintenance Workers	15,168	16,510	235,259	14.25	17
18	Housekeepers	19,921	21,737	264,833	12.18	18
19	Laundry					19
20	Administrator	1,893	2,161	115,637	53.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,722	4,143	73,404	17.72	23
24	Clerical	4,964	5,414	80,097	14.79	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)	12,369	13,246	165,253	12.48	33
34	TOTAL (lines 1 - 33)	210,363	230,140	$ 3,863,577 *	$ 16.79	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	182	$ 15,526	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	13,613	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	Psychiatrist	Monthly	14,250	10-03	47
48					48
49	TOTAL (lines 35 - 48)	182	$ 50,589		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	70	$ 3,716	10-03	50
51	Licensed Practical Nurses	429	19,397	10-03	51
52	Certified Nurse Assistants/Aides	16	431	10-03	52
53	TOTAL (lines 50 - 52)	515	$ 23,544		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline L. Gully	Administrator	0	$ 115,637
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 115,637

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
Propay Payroll Solution	Data Processing	$ 27,749
Reimb Achieve	Data Processing	24,353
National Datacare Corp	Data Processing	4,080
Ability Network	Data Processing	202
Marcum LLP	Accounting Fees	22,819
S4 Group	Lobbying (ADJ. on PG. 5A)	3,184
Blymas	Tax Consulting	6,975
Kelleher, Helmrich	MSDS Services	689
Benefit Services Group	401K Consulting	206
Setec, Inc.	Security	158
Pinnacle Quality Insight	Satisfaction Survey	1,214
See Supplemental Schedule		373,633
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 465,261

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,981
Unemployment Compensation Insurance	81,416
FICA Taxes	289,717
Employee Health Insurance	221,295
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	766
Pension Expense	30,399
Other Employee Expense	4,671
Holiday Expense	4,689
TOTAL (agree to Schedule V, line 22, col.8)	$ 739,934

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

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,161
Advertising: Employee Recruitment	23,916
Health Care Worker Background Check	
(Indicate # of checks performed 318.4)	3,184
Patient Background Checks 164	1,640
Dues and Subscriptions	26,562
Licences and Fees	3,141
Allocated from Extended Care Consulting	1,008
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 60,612

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,897
Allocated from Extended Care Consulting	43
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,940

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rainbow Beach Care Center # 0054247 **Report Period Beginning:** 01/01/17 **Ending:** 12/31/17

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. $ _____ 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% Ln14**
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