FOR BHF USE

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2018
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2018)

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.

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 01/01/18 to 12/31/18 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) Steven N. Lavenda, CPA, Partner

(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: 01/01/18 Ending: 12/31/18

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	61,998	2		62,000	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	61,998	2		62,000	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.50%

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

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

Tax Year: 12/31/18 Fiscal Year: 12/31/18

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	336,731	37,865	13,288	387,884		387,884	240	388,124			1
2	Food Purchase		361,627		361,627		361,627	489	362,116			2
3	Housekeeping	286,666	57,204		343,870		343,870	1,307	345,177			3
4	Laundry		22,634	33,586	56,220		56,220		56,220			4
5	Heat and Other Utilities			198,016	198,016		198,016	1,953	199,969			5
6	Maintenance	252,420		170,248	422,668		422,668	19,490	442,158			6
7	Other (specify):*							998	998			7
8	TOTAL General Services	875,817	479,330	415,138	1,770,285		1,770,285	24,477	1,794,762			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,013,824	42,081	33,040	2,088,945		2,088,945	(1,907)	2,087,038			10
10a	Therapy											10a
11	Activities	222,303	14,952		237,255		237,255		237,255			11
12	Social Services	571,004	43,069		614,073		614,073		614,073			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,807,131	100,102	40,240	2,947,473		2,947,473	(1,907)	2,945,566			16
	C. General Administration											
17	Administrative	114,806			114,806		114,806	23,391	138,197			17
18	Directors Fees											18
19	Professional Services			457,020	457,020	(3,506)	453,514	(352,473)	101,041			19
20	Dues, Fees, Subscriptions & Promotions			123,758	123,758		123,758	(46,112)	77,646			20
21	Clerical & General Office Expenses	161,787	25,895	54,875	242,557		242,557	149,258	391,815			21
22	Employee Benefits & Payroll Taxes			696,069	696,069		696,069	(7,490)	688,579			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,522	3,522		3,522	456	3,978			24
25	Other Admin. Staff Transportation			20,779	20,779		20,779	1,207	21,986			25
26	Insurance-Prop.Liab.Malpractice			356,707	356,707		356,707	28,551	385,258			26
27	Other (specify):*							35,069	35,069			27
28	TOTAL General Administration	276,593	25,895	1,712,730	2,015,218	(3,506)	2,011,712	(168,143)	1,843,569			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,959,541	605,327	2,168,108	6,732,976	(3,506)	6,729,470	(145,573)	6,583,897			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: 01/01/18 Ending: 12/31/18

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,379	73,379		73,379	301,369	374,748			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,128	1,128		1,128	871,306	872,434			32
33	Real Estate Taxes					3,506	3,506	334,545	338,051			33
34	Rent-Facility & Grounds			2,082,000	2,082,000		2,082,000	(2,082,000)				34
35	Rent-Equipment & Vehicles			15,941	15,941		15,941	601	16,542			35
36	Other (specify):*			150,353	150,353		150,353	(34,420)	115,933			36
37	**TOTAL Ownership**			2,322,801	2,322,801	3,506	2,326,307	(608,599)	1,717,708			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)**	3,959,541	605,327	4,490,909	9,055,777		9,055,777	(754,172)	8,301,605			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: 01/01/18 Ending: 12/31/18

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,999)	30		9
10	Interest and Other Investment Income	(25,311)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(28,000)	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		21		24
25	Fund Raising, Advertising and Promotional	(5,722)	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	(198,495)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (260,527)		$	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)	(493,645)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (493,645)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (754,172)		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: 01/01/18

Ending: 12/31/18

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Patient Clothing	$ (261)	10	1
2	Theft Loss	(1,702)	21	2
3	Collection Expense	(2,448)	21	3
4	Amortization	(150,353)	36	4
5	Alliance for Living - Lobbying	(14,792)	20	5
6	Non-Allowable Legal Fees	(2,451)	19	6
7	Additional R & M	6,450	06	7
8	Capitalized R & M	(3,239)	06	8
9	Building Company - Management Fee	(10,550)	19	9
10	Building Company - Audit Fee	(10,500)	19	10
11	Building Company - Filing Fee	(75)	21	11
12	Building Company - Amortization Expense	(8,025)	36	12
13	Lobbying Expense	(265)	19	13
14	Convenience Fee & Late Fee	(284)	33	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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**	(198,495)		49

Rainbow Beach Care Center

ID# 0054247

Report Period Beginning: 01/01/18

Ending: 12/31/18

	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: 01/01/18 Ending: 12/31/18

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

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			240									240	1
2	Food Purchase			489									489	2
3	Housekeeping			1,307									1,307	3
4	Laundry													4
5	Heat and Other Utilities			1,953									1,953	5
6	Maintenance	3,211		5,230	11,049								19,490	6
7	Other (specify):*				998								998	7
8	**TOTAL General Services**	3,211		9,219	12,047								24,477	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(261)					(1,646)						(1,907)	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**	(261)					(1,646)						(1,907)	16
	C. General Administration													
17	Administrative			1,874	21,517								23,391	17
18	Directors Fees													18
19	Professional Services	(23,766)	21,050	(349,757)									(352,473)	19
20	Fees, Subscriptions & Promotions	(48,514)		2,402									(46,112)	20
21	Clerical & General Office Expenses	(4,225)	75	12,328	141,080								149,258	21
22	Employee Benefits & Payroll Taxes				(7,490)								(7,490)	22
23	Inservice Training & Education													23
24	Travel and Seminar			456									456	24
25	Other Admin. Staff Transportation			1,207									1,207	25
26	Insurance-Prop.Liab.Malpractice		26,356	2,195									28,551	26
27	Other (specify):*				35,069								35,069	27
28	**TOTAL General Administration**	(76,505)	47,481	(329,295)	190,176								(168,143)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(73,555)	47,481	(320,076)	202,223		(1,646)						(145,573)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rainbow Beach Care Center # 0054247 **Report Period Beginning:** 01/01/18 **Ending:** 12/31/18

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

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(2,999)	301,177	3,191									301,369	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(25,311)	869,255	27,362									871,306	32
33	Real Estate Taxes	(284)	329,053	5,776									334,545	33
34	Rent-Facility & Grounds		(2,082,000)										(2,082,000)	34
35	Rent-Equipment & Vehicles			601									601	35
36	Other (specify):*	(158,378)	123,958										(34,420)	36
37	**TOTAL Ownership**	(186,972)	(458,557)	36,930									(608,599)	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)**	(260,527)	(411,076)	(283,146)	202,223		(1,646)						(754,172)	45

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

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		$	$ (2,082,000)	1
2	V	32	Interest Income	272	Rainbow Beach Real Estate			(272)	2
3	V	19	Management Fee		Rainbow Beach Real Estate		10,550	10,550	3
4	V	19	Audit Fee		Rainbow Beach Real Estate		10,500	10,500	4
5	V	21	Filing Fee		Rainbow Beach Real Estate		75	75	5
6	V	36	Amortization Expense		Rainbow Beach Real Estate		8,025	8,025	6
7	V	33	Real Estate Tax Expenses		Rainbow Beach Real Estate		329,053	329,053	7
8	V	26	Insurance		Rainbow Beach Real Estate		26,356	26,356	8
9	V	32	Interest Expense - HUD		Rainbow Beach Real Estate		869,527	869,527	9
10	V	36	Mortgage Insurance Premium		Rainbow Beach Real Estate		115,933	115,933	10
11	V	30	Depreciation Expense		Rainbow Beach Real Estate		301,177	301,177	11
12	V								12
13	V								13
14	Total			$ 2,082,272			$ 1,671,196	$ * (411,076)	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: 01/01/18 Ending: 12/31/18

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		$ 240	$ 240	15
16	V	02	Food		Extended Care Consulting, LLC		489	489	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,307	1,307	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,953	1,953	18
19	V	06	Maintenance		Extended Care Consulting, LLC		5,230	5,230	19
20	V	17	Administrative		Extended Care Consulting, LLC		1,874	1,874	20
21	V	19	Professional Fees	356,592	Extended Care Consulting, LLC		6,835	(349,757)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		2,402	2,402	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		12,328	12,328	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		456	456	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		1,207	1,207	25
26	V	26	Insurance		Extended Care Consulting, LLC		2,195	2,195	26
27	V	30	Depreciation		Extended Care Consulting, LLC		3,191	3,191	27
28	V	32	Interest		Extended Care Consulting, LLC		27,362	27,362	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		5,776	5,776	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		601	601	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			$ 73,446	$ * (283,146)	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: 01/01/18 Ending: 12/31/18

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		11,049	$ 11,049	15
16	V	06	Maintenance (Direct)	504	Extended Care Consulting, LLC		504		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC		958	958	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC		40	40	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC		21,517	21,517	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC		140,902	140,902	22
23	V	21	Office and Clerical (Direct)	24,464	Extended Care Consulting, LLC		24,642	178	23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC		32,480	32,480	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC		2,589	2,589	25
26	V	22	Employee Benefits	7,490	Extended Care Consulting, LLC			(7,490)	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			$ 32,458			$ 234,681	$ * 202,223	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: 01/01/18 Ending: 12/31/18

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	Various Equipment	11,380	Vent Lease LLC	100.00%	11,380	$	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			$ 11,380			$ 11,380	$ *	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: 01/01/18 Ending: 12/31/18

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	19,098	MAC Rx, LLC		17,452	(1,646)	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			$ 19,098			$ 17,452	$ * (1,646)	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: 01/01/18 Ending: 12/31/18

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		$ 154,210	$ 154,210	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	154,210	CCS Employee Benefits Group			(154,210)	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			$ 154,210			$ 154,210	$ *	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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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%	CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CONSULTIN	EVANSTON	MGMT/BOOKKEEPING	2
3			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			GRASMERE PLACE, LLC	CHICAGO	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			MAJOR HOSPITAL DYER	DYER, IN	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				8
9			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				9
10			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				10
11			MAJOR HOSPITAL SEBOS	HOBART, IN				11
12			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			NAPERVILLE MANOR HEALTH & REHAB CENTER	NAPERVILLE				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			SPRING CREEK NURSING & REHAB CENTER	JOLIET				22
23			ST. JAMES WELLNESS REHAB VILLAS	CRETE				23
24			THE ESTATES OF HYDE PARK	CHICAGO				24
25			THE PARC AT JOLIET	JOLIET				25
26			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				26
27			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				27
28								28
29								29
30								30

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	1.23	2.23%	Alloc Sal/Fee	$ 1,874	17-07	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.73	1.83%	Alloc Salary	1,387	22-07	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	$ 3,261		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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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	1,389,746	40	$ 5,386	$	62,000	$ 240	1
2	02	Food	Patient Days	1,389,746	40	10,961		62,000	489	2
3	03	Housekeeping	Patient Days	1,389,746	40	29,295		62,000	1,307	3
4	05	Utilities	Patient Days	1,389,746	40	43,781		62,000	1,953	4
5	06	Maintenance	Patient Days	1,389,746	40	117,234		62,000	5,230	5
6	17	Administrative	Patient Days	1,389,746	40	42,000		62,000	1,874	6
7	19	Professional Fees	Patient Days	1,389,746	40	153,207		62,000	6,835	7
8	20	Dues and Subscriptions	Patient Days	1,389,746	40	53,847		62,000	2,402	8
9	21	Office and Clerical	Patient Days	1,389,746	40	276,330		62,000	12,328	9
10	24	Seminar and Travel	Patient Days	1,389,746	40	10,217		62,000	456	10
11	25	Other Staff Admin. Trans.	Patient Days	1,389,746	40	27,054		62,000	1,207	11
12	26	Insurance	Patient Days	1,389,746	40	49,193		62,000	2,195	12
13	30	Depreciation	Patient Days	1,389,746	40	71,516		62,000	3,191	13
14	32	Interest	Patient Days	1,389,746	40	613,328		62,000	27,362	14
15	33	Real Estate Taxes	Patient Days	1,389,746	40	129,471		62,000	5,776	15
16	35	Rent - Equipment	Patient Days	1,389,746	40	13,470		62,000	601	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,646,291	$		$ 73,446	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	1,389,746	40	247,664	247,664	62,000	11,049	1
2	06	Maintenance (Direct)	Direct		25	357,298	357,298		504	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,389,746	40	21,482		62,000	958	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		25	47,140			40	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,389,746	40	482,303	482,303	62,000	21,517	7
8	21	Office and Clerical (Pooled)	Patient Days	1,389,746	40	3,158,355	3,158,355	62,000	140,902	8
9	21	Office and Clerical (Direct)	Direct		28	484,472	484,472		24,642	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,389,746	40	728,044		62,000	32,480	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		28	72,742			2,589	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					$ 5,599,498	$ 4,730,091		$ 234,681	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

VIII. ALLOCATION OF INDIRECT COSTS

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

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

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

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Various Equipment	Direct Allocation						11,380	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					$	$		$ 11,380	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

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						17,452	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					$	$		$ 17,452	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

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			$	$		$ 154,210	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					$	$		$ 154,210	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HUD		X	Mortgage			$	$ 22,949,936			$ 869,527	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 22,949,936			$ 869,527	9
	B. Non-Facility Related*											
10	Interest Income		X								(25,311)	10
11	Other Interest Expense		X								1,128	11
12	Interest Income - Bldg Co	X									(272)	12
13	Allocated from Extended Care Consulting										27,362	13
14	TOTAL Non-Facility Related						$	$			$ 2,907	14
15	TOTALS (line 9+line14)						$	$ 22,949,936			$ 872,434	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 115,933 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: 01/01/18 Ending: 12/31/18

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2017 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 302,239	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.)		$ 313,504	2
3. Under or (over) accrual (line 2 minus line 1).		$ 11,265	3
4. Real Estate Tax accrual used for 2018 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 323,280	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.)**		$ 3,506	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 $ 873 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.		$ 338,051	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2013	256,086	8
	2014	261,098	9
	2015	265,733	10
	2016	287,847	11
	2017	307,728	12

2018 Accrual = $307,728 + 5% (307,728 * 1.05 = 323,114)

Allocated from Extended Care Consulting - $5,776

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2017	$	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.

2017 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 2017 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 2017.

	(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	$ 2,135.69	$ 2,135.69
2.	21-30-112-007-0000	Long Term Care Property	$ 19,483.21	$ 19,483.21
3.	21-30-112-008-0000	Long Term Care Property	$ 21,875.52	$ 21,875.52
4.	21-30-112-011-0000	Long Term Care Property	$ 379.50	$ 379.50
5.	21-30-112-012-0000	Long Term Care Property	$ 379.50	$ 379.50
6.	21-30-112-013-0000	Long Term Care Property	$ 53,684.19	$ 53,684.19
7.	21-30-112-014-0000	Long Term Care Property	$ 68,015.87	$ 68,015.87
8.	21-30-112-017-0000	Long Term Care Property	$ 1,144.83	$ 1,144.83
9.	21-30-112-018-0000	Long Term Care Property	$ 1,151.66	$ 1,151.66
10.	21-30-112-051-0000	Long Term Care Property	$ 128,697.45	$ 128,697.45
		TOTALS	$ 296,947.42	$ 296,947.42

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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.

2017 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 2017 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 2017.

	(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	$ 10,780.71	$ 10,780.71
2.	See Attached	Care Center Building Allocation	$ 129,470.54	$ 5,776.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 140,251.25	$ 16,556.71

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 2017 tax bills which were listed in Section A to this statement. Be sure to use the 2017 tax bill which is normally paid during 2018.

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: 01/01/18 Ending: 12/31/18

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			24,807	2
3	TOTALS			$ 509,816	3

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/18 Ending: 12/31/18

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	$ 301,177	39	$ 244,853	$ (56,324)	$ 3,427,942	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			2005	39,668		20	1,983	1,983	26,115	9
10	Various			2006	322,466		20	11,998	11,998	235,056	10
11	Various			2007	131,026		20	4,803	4,803	97,720	11
12	Various			2008	248,335		20	11,837	11,837	136,366	12
13	Various			2009	98,114		20	3,874	3,874	51,926	13
14	Various			2010	28,177		20	1,409	1,409	11,837	14
15	Various			2011	61,398		20	2,889	2,889	28,224	15
16	Various			2012	301,177		20	15,059	15,059	99,055	16
17	Various			2013	93,355		20	3,953	3,953	43,142	17
18	Various			2014	78,933		20	6,422	6,422	28,529	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: 01/01/18 Ending: 12/31/18

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)		729,006			36,452	36,452	134,742	67
68	Related Party Allocations (Pages 12H & 12I)		124,716	1,946		1,946		83,725	68
69	Financial Statement Depreciation			73,379			(73,379)		69
70	TOTAL (lines 4 thru 69)		$ 11,805,637	$ 376,502		$ 347,478	$ (29,025)	$ 4,404,378	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: 01/01/18 Ending: 12/31/18

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		$ 11,805,637	$ 376,502		$ 347,478	$ (29,025)	$ 4,404,378	1
2	Replace Domestic Booster Pump	2015	6,137		20	307	307	1,227	2
3	Replace Motor And Sheave In Boiler	2015	3,228		20	161	161	565	3
4	Install Steel Fire Rated Door, Replace 9 Glass Blocks, Caulk 1St Flo	2015	12,000		20	600	600	1,850	4
5	Install 4 Shower Drains & 2 Common Drains	2015	3,500		20	175	175	613	5
6	Install New Relay & Controller For Damper	2015	6,626		20	331	331	1,022	6
7	Install New Pump & Soft Starter For Elevator	2015	17,290		20	865	865	3,242	7
8	Install Detector Edge In Large Passenger Elevator	2015	2,881		20	144	144	540	8
9	Install New Pana 40 Door Edge In Passenger Elevator	2015	3,048		20	152	152	521	9
10	Replace Victalic Seals In # 2 Passenger Elevator	2015	2,898		20	145	145	495	10
11	Boiler Repair	2016	5,454		20	273	273	818	11
12	Sewer Repair	2016	4,500		20	225	225	600	12
13	Sewer Repair	2016	7,150		20	358	358	804	13
14	Sewer Repair	2016	7,600		20	380	380	855	14
15	Concrete Walk Way	2016	5,500		20	275	275	573	15
16	Replaced Defective Safety Edge Passenger Elevator	2016	2,629		20	131	131	340	16
17	Replaced Passenger Elevator Main Line, Replaced Door Board	2016	2,619		20	131	131	284	17
18	Replaced Packing On North Passenger Elevator	2016	4,585		20	229	229	669	18
19	Fire Alarm System - New Annunciator For Floors 1-5	2017	6,089		20	304	304	609	19
20	Southwest Cafeteria Fire Exit Door	2017	10,350		20	518	518	949	20
21	2Nd Floor Bathroom Remodel-New Showers, Floor & Wall Tile	2017	9,060		20	453	453	793	21
22	Masonry Tuck Pointing - Back Of Building	2017	40,000		20	2,000	2,000	3,500	22
23	2Nd Floor Bathroom - New Showers, Drains, Walls	2017	7,700		20	385	385	642	23
24	Duct Work Replacement & New Air Conditioners	2017	6,816		20	1,363	1,363	2,045	24
25	Magnetic Locks On 1St Floor	2017	3,852		20	193	193	273	25
26	Hvac - Roof Top Exhaust Fan Replacement	2017	3,000		20	150	150	200	26
27	5Th Floor Roof Coating	2017	4,900		20	245	245	306	27
28	1St Floor Roof Coating	2017	3,500		20	175	175	219	28
29	Repack Cylinder Heads On Elevator	2017	3,450		20	173	173	331	29
30	Replaced Pump Motor On Elevator	2017	7,495		20	375	375	656	30
31	Install New Door Board In Large Elevator	2017	3,270		20	164	164	259	31
32	Install New Selector Board In Elevator #1	2017	7,788		20	389	389	487	32
33	Install New Car Board In Big Passenger Elevator	2017	5,550		20	278	278	347	33
34	TOTAL (lines 1 thru 33)		$ 12,026,103	$ 376,502		$ 359,523	$ (16,979)	$ 4,431,009	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: 01/01/18 Ending: 12/31/18

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		$ 12,026,103	$ 376,502		$ 359,523	$ (16,979)	$ 4,431,009	1
2	Install New Clc Board In Large Passenger Elevator	2017	2,855		20	143	143	155	2
3	Elevator Maintenance On Both Elevators	2017	4,267		20	213	213	231	3
4	Install New Clc Board In Large Passenger Elevator	2017	3,307		20	165	165	179	4
5	Repair Wiring On P24C Circuit In Large Passenger Elevator	2017	2,501		20	125	125	135	5
6	Install New Door Board In Elevator #1	2017	4,941		20	247	247	391	6
7	Window Screen Replacement & Laundry Water Valves	2018	7,650		20	287	287	287	7
8	3Rd Floor Hvac Duct Work Replacement	2018	6,915		20	259	259	259	8
9	3Rd Floor Hvac Duct Work Replacement, Door Parts For Lunch Rc	2018	5,050		20	189	189	189	9
10	3Rd Floor Hvac Duct Work Replacement	2018	7,950		20	298	298	298	10
11	Kitchen Plumbing / 3Rd Floor Hvac Duct Work / Lighting	2018	7,850		20	294	294	294	11
12	Elevator Sump Pump Replacement / Ground Floor Hvac Duct Worl	2018	7,850		20	294	294	294	12
13	Clean Windows, Tuckpoint By Patio, Bathroom Demo	2018	7,410		20	278	278	278	13
14	Front Hall Mens Bathrm-Walls/Ceiling Painting, Fixtures, Plumbin	2018	8,690		20	290	290	290	14
15	Women'S Bathrm-Wall Painting, Ceiling Tiles, Electrical Repair	2018	6,250		20	208	208	208	15
16	New Roof Top Ac Unit	2018	12,500		20	417	417	417	16
17	Trane Chiller - New Keypad	2018	4,226		20	141	141	141	17
18	Installed New Electrical Junction Box	2018	6,285		20	183	183	183	18
19	Resident Rooms Window & Dry Walls Replacement	2018	6,480		20	135	135	135	19
20	Boiler Room- Insulate Water Pipes / Repair Window Frames	2018	6,165		20	103	103	103	20
21	Resident Rms-Install 5 New Light Fixtures/Repair Damaged Walls	2018	6,350		20	106	106	106	21
22	Rms 49-51,53,56,59-Dry Wall Repairs/Caulked Doors & Windows	2018	6,220		20	104	104	104	22
23	Resident Room Window Replacement / Activity Room Door Repair	2018	4,550		20	76	76	76	23
24	Resident Room Window Replacement	2018	3,527		20	59	59	59	24
25	Resident Room Window Replacement	2018	6,955		20	116	116	116	25
26	Install New Electrical Panel	2018	11,000		20	275	275	275	26
27	Exit Door Hardware & Window Screen Replacement	2018	5,200		20	238	238	238	27
28	New Bathroom Sink, Window Screen Replacement, New Lighting F	2018	11,070		20	461	461	461	28
29	Service A/C Units, Window Screen Replacement, Repoured Concret	2018	7,060		20	206	206	206	29
30	Rod Out Toilets, Exit Sign Installation, Window Screen Replacemer	2018	6,935		20	202	202	202	30
31	Electrical Work On Back Of Facility, New Lighting Fixtures, Insula	2018	7,780		20	227	227	227	31
32	Resident Rms-Plumbing Repairs, Wall Painting, Electrical Repairs	2018	7,930		20	231	231	231	32
33	Front Hallway Washroom - Drywall, Paint, New Fixtures	2018	6,740		20	225	225	225	33
34	TOTAL (lines 1 thru 33)		$ 12,236,562	$ 376,502		$ 366,319	$ (10,183)	$ 4,438,003	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: 01/01/18 Ending: 12/31/18

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		$ 12,236,562	$ 376,502		$ 366,319	$ (10,183)	$ 4,438,003	1
2	Resident Room Window & Screen Replacement	2018	4,540		20	38	38	38	2
3	Resident Room Window Replacement & Plumbing Repairs	2018	5,949		20	50	50	50	3
4	Replace Packing On The Elevator & Add Hydro Oil	2018	3,239		20	162	162	162	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,250,290	$ 376,502		$ 366,569	$ (9,933)	$ 4,438,252	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: 01/01/18 Ending: 12/31/18

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		$ 12,250,290	$ 376,502		$ 366,569	$ (9,933)	$ 4,438,252	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 12,250,290	$ 376,502		$ 366,569	$ (9,933)	$ 4,438,252	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: 01/01/18 Ending: 12/31/18

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	38,131	9
10	2 Electromagnetic Locks	2010	4,175		20	209	209	1,880	10
11	Security Camera	2010	2,790		20	140	140	1,258	11
12	Masonry Repairs	2010	10,820		20	541	541	4,869	12
13	Repair Glass Block	2010	8,700		20	435	435	3,915	13
14	Egress Locks and Delayed Egress Locks	2010	21,800		20	1,090	1,090	9,810	14
15	200 Amp Electric Sub Panel	2010	3,250		20	163	163	1,465	15
16	Privacy Curtains	2010	10,028		20	501	501	4,511	16
17	New Fence	2015	24,500		20	1,225	1,225	4,900	17
18	Installed Floor Tiles in Four Shower Stalls	2015	18,500		20	925	925	3,700	18
19	IP Office Phone System	2015	24,843		20	1,242	1,242	4,968	19
20	Roof Repairs	2016	190,560		20	9,528	9,528	28,584	20
21	1st Flr Bathroom-new concrete floors, shower wall/floor tile, caulk	2016	9,500		20	475	475	1,425	21
22	Waterproof Membrane	2016	17,000		20	850	850	2,550	22
23	Fence Painting	2016	9,800		20	490	490	1,470	23
24	Hot Water Tank	2016	15,000		20	750	750	2,250	24
25	1st Flr Bathroom-new concrete floors/plumbing,wall/floor tile	2017	14,990		20	750	750	1,250	25
26	1st Floor Bathroom - new floor tile, repair & paint walls	2017	3,850		20	193	193	321	26
27	Masonry Tuckpointing - Back of Building	2017	48,000		20	2,400	2,400	3,800	27
28	Electrical Work-offices, kitchen, remove exhaust fan	2017	4,190		20	210	210	332	28
29	Duct Work Replacement & New Air Conditioners	2017	30,450		20	1,523	1,523	3,046	29
30	Masonry Tuckpointing	2017	48,000		20	2,400	2,400	3,400	30
31	New exterior door and masonry	2017	10,000		20	500	500	667	31
32	1st Floor Roof Coating	2017	13,050		20	653	653	816	32
33	Masonry Tuckpointing - Back of Building	2017	48,000		20	2,400	2,400	2,800	33
34	TOTAL (lines 1 thru 33)		$ 676,526	$		$ 33,828	$ 33,828	$ 132,118	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: 01/01/18 Ending: 12/31/18

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		$ 676,526	$		$ 33,828	$ 33,828	$ 132,118	1
2	HVAC Duct Work	2018	4,200		20	210	210	210	2
3	HVAC Duct Work & Water Fountain Replacement	2018	7,415		20	371	371	371	3
4	HVAC Duct Work & Water Fountain Replacement	2018	5,500		20	275	275	275	4
5	Resident Rm-Toilet Repair/Light Fixtures/Window Screen Replacer	2018	8,950		20	448	448	448	5
6	Window Screen Replacement - Ground Floor	2018	8,500		20	425	425	425	6
7	Window Screen Replacement - Ground Floor	2018	6,755		20	338	338	338	7
8	Window Screen Replacement & Replace Back Door Hardware	2018	4,745		20	237	237	237	8
9	Window Screen Replacement - Ground Floor	2018	6,415		20	321	321	321	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 729,006	$		$ 36,452	$	$ 134,742	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: 01/01/18 Ending: 12/31/18

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	34,186	877	35	877		14,280	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	10,707	237	35	237		2,727	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Extended Care Consulting-Care Center Bldg	2002	28,240		20			28,240	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2003	33,280		20			33,280	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,654		20			1,654	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2009	298	15	20	15		149	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2014	2,864	143	20	143		716	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2015	470	24	20	24		203	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2016	1,858	93	20	93		279	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,223	161	20	161		322	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,477	74	20	74		74	17
18	Allocated from Extended Care Consulting	2007	205	10	20	10		123	18
19	Allocated from Extended Care Consulting	2009	123	6	20	6		62	19
20	Allocated from Extended Care Consulting	2010	1,204	60	20	60		542	20
21	Allocated from Extended Care Consulting	2011	433	22	20	22		173	21
22	Allocated from Extended Care Consulting	2012	143	7	20	7		50	22
23	Allocated from Extended Care Consulting	2014	1,979	99	20	99		495	23
24	Allocated from Extended Care Consulting	2016	2,372	119	20	119		356	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)		$ 124,716	$ 1,946		$ 1,946	$	$ 83,725	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: 01/01/18 Ending: 12/31/18

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		$ 124,716	$ 1,946		$ 1,946	$	$ 83,725	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 124,716	$ 1,946		$ 1,946	$	$ 83,725	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: 01/01/18 Ending: 12/31/18

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	$ 55,772	$ 1,017	$ 7,891	$ 6,874	10	$ 41,672	71
72	Current Year Purchases	3,627		60	60	10	60	72
73	Fully Depreciated Assets	1,678,812				10	1,678,812	73
74								74
75	TOTALS	$ 1,738,211	$ 1,017	$ 7,951	$ 6,934		$ 1,720,545	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			2014	$ 1,136	$ 227	$ 227	$ 0	5	$ 1,136	76
77										77
78										78
79										79
80	TOTALS			$ 1,136	$ 227	$ 227	$ 0		$ 1,136	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)	$ 14,499,453	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 377,746	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 374,748	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,999)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,159,933	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: 01/01/18 Ending: 12/31/18

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.	/2019	$
13.	/2020	$
14.	/2021	$

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: $ 16,542 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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

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: 01/01/18 Ending: 12/31/18

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/18 (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	$ 298,522	$ 702,606	1
2	Cash-Patient Deposits	27,693	27,693	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	526,933	526,933	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	75,355	202,107	6
7	Other Prepaid Expenses	4,827	4,827	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule		502,304	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 933,330	$ 1,966,470	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		10,190,330	14
15	Leasehold Improvements, at Historical Cost	1,298,250	1,298,250	15
16	Equipment, at Historical Cost	351,746	1,755,590	16
17	Accumulated Depreciation (book methods)	(1,228,166)	(6,611,288)	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	1,052,467	1,259,573	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,474,297	$ 8,377,464	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,407,627	$ 10,343,934	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 9,760,199	$ 8,010,737	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,645	13,645	28
29	Short-Term Notes Payable		534,245	29
30	Accrued Salaries Payable	317,521	317,521	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,363	13,363	31
32	Accrued Real Estate Taxes(Sch.IX-B)		323,280	32
33	Accrued Interest Payable		71,719	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	303	303	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 10,105,031	$ 9,284,813	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		22,415,691	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule		996,816	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 23,412,507	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 10,105,031	$ 32,697,320	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (7,697,404)	$ (22,353,386)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,407,627	$ 10,343,934	48

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (7,331,409)	1
2	Restatements (describe):		2
3	**Prior Year Repairs & Maintenance**	3,340	3
4	**Prior Year Depreciation**	3,843	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (7,324,226)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(373,178)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (373,178)	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)**	$ (7,697,404)	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	$ 8,616,922	1
2	Discounts and Allowances for all Levels	(26,752)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,590,170	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	967	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)**	$ 967	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	25,311	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 25,311	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	66,151	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 66,151	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,682,599	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,770,285	31
32	Health Care	2,947,473	32
33	General Administration	2,015,218	33
	B. Capital Expense		
34	Ownership	2,322,801	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)***	$ 9,055,777	40
41	**Income before Income Taxes (line 30 minus line 40)****	(373,178)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (373,178)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 8,589,820	44
45	Private Pay - Net Inpatient Revenue	350	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)	$ 8,590,170	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	1,933	2,173	$ 98,028	$ 45.11	1
2	Assistant Director of Nursing	1,933	2,086	75,781	36.33	2
3	Registered Nurses	7,674	8,191	262,580	32.06	3
4	Licensed Practical Nurses	19,361	21,603	624,316	28.90	4
5	CNAs & Orderlies	52,438	58,030	799,615	13.78	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,768	4,367	67,304	15.41	9
10	Activity Assistants	10,069	10,819	154,999	14.33	10
11	Social Service Workers	23,853	26,294	552,231	21.00	11
12	Dietician	1,575	1,882	26,412	14.03	12
13	Food Service Supervisor	1,907	2,155	44,935	20.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,126	4,381	56,809	12.97	15
16	Dishwashers	14,684	16,234	208,575	12.85	16
17	Maintenance Workers	14,860	16,171	252,420	15.61	17
18	Housekeepers	20,609	22,303	286,666	12.85	18
19	Laundry					19
20	Administrator	1,900	2,094	114,806	54.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,602	4,037	73,301	18.16	23
24	Clerical	5,014	5,622	88,486	15.74	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	11,730	12,778	172,278	13.48	33
34	TOTAL (lines 1 - 33)	201,035	221,221	$ 3,959,542 *	$ 17.90	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	235	$ 13,288	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	13,651	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	12,000	10-03	47
48					48
49	TOTAL (lines 35 - 48)	235	$ 46,139		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	73	$ 4,286	10-03	50
51	Licensed Practical Nurses	72	3,103	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	145	$ 7,389		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline L. Gully	Administrator	0	$ 114,806
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 114,806

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	Payroll Processing	$ 25,227
Achieve	Data Processing	25,320
National Datacare Corp	Resident Trust Fund Manageme	2,857
Ability Network	Eligibility Software	2,673
Marcum LLP	Accounting Fees	20,846
S4 Group	Lobbying (ADJ. on PG. 5A)	265
Blymas	Tax Consulting	2,057
Kelleher	MSDS Services	728
Benefit Services Group	401K Consulting	230
Red Eyed Moose	Technology Consultant	4,304
Pinnacle Quality Insight	Satisfaction Survey	1,011
See Supplemental Schedule		371,502
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 457,021

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 111,665
Unemployment Compensation Insurance	55,516
FICA Taxes	295,463
Employee Health Insurance	108,254
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	33,517
Other Employee Expense	5,100
Holiday Expense	3,119
TOTAL (agree to Schedule V, line 22, col.8)	$ 612,634

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

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	42,692
Health Care Worker Background Check	
(Indicate # of checks performed 68)	4,035
Patient Background Checks 196	1,960
Dues and Subscriptions	23,592
Licences and Fees	2,965
Alloc. Extended Care Consulting	2,402
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 77,646

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,522
Allocated from Extended Care Consulting	456
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,978

**See instructions.

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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. $ **609** Line **10**

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

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

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

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

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

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

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

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

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

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

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

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

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