

		FOR BHF USE					

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2016
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2016)

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: 0047332 Facility Name: Rainbow Beach Care Center Address: 7325 S Exchange St Chicago 60649 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 ☐ Charitable Corp. ☐ Trust IRS Exemption Code ☒ PROPRIETARY ☐ Individual ☐ Partnership ☐ Corporation ☐ "Sub-S" Corp. ☒ Limited Liability Co. ☐ Trust ☐ Other ☐ GOVERNMENTAL ☐ State ☐ County ☐ Other
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In the event there are further questions about this report, please contact:

Name: Steven N. Lavenda

Telephone Number: (847) 282-6300

Email Address:

Facility Name & ID Number Rainbow Beach Care Center

0047332 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	211	Intermediate (ICF)	211	77,226	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	211	77,226	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	64,305			64,305	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	64,305			64,305	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.27%

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

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

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

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

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

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 ☒ Date 08/01/2005 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2016 Fiscal Year: 12/31/2016

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

Facility Name & ID Number **Rainbow Beach Care Center** # **0047332** Report Period Beginning: **01/01/16** Ending: **12/31/16**

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

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	309,168	49,366	22,642	381,176		381,176	242	381,418			1
2	Food Purchase		349,990		349,990		349,990	522	350,512			2
3	Housekeeping	236,909	67,640		304,549		304,549	1,341	305,890			3
4	Laundry	719	12,480	58,311	71,510		71,510		71,510			4
5	Heat and Other Utilities			183,504	183,504		183,504	(1,261)	182,243			5
6	Maintenance	216,293	8	167,123	383,424		383,424	5,783	389,207			6
7	Other (specify):*							1,225	1,225			7
8	TOTAL General Services	763,089	479,484	431,580	1,674,153		1,674,153	7,852	1,682,005			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,936,227	46,808	34,920	2,017,955		2,017,955	(1,290)	2,016,665			10
10a	Therapy	1,008	360		1,368		1,368		1,368			10a
11	Activities	210,150	20,257		230,407		230,407		230,407			11
12	Social Services	574,832	32,933		607,765		607,765		607,765			12
13	CNA Training											13
14	Program Transportation			2,074	2,074		2,074		2,074			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,722,217	100,358	44,194	2,866,769		2,866,769	(1,290)	2,865,479			16
	C. General Administration											
17	Administrative	158,054			158,054		158,054	26,182	184,236			17
18	Directors Fees											18
19	Professional Services			486,733	486,733	(27,270)	459,463	(353,945)	105,518			19
20	Dues, Fees, Subscriptions & Promotions			70,364	70,364		70,364	(18,878)	51,486			20
21	Clerical & General Office Expenses	126,211	31,392	469,946	627,549		627,549	(282,443)	345,106			21
22	Employee Benefits & Payroll Taxes			728,097	728,097		728,097	(6,170)	721,927			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,963	10,963		10,963	199	11,162			24
25	Other Admin. Staff Transportation			22,843	22,843		22,843	1,353	24,196			25
26	Insurance-Prop.Liab.Malpractice			175,445	175,445		175,445	33,848	209,293			26
27	Other (specify):*							31,191	31,191			27
28	TOTAL General Administration	284,265	31,392	1,964,391	2,280,048	(27,270)	2,252,778	(568,663)	1,684,115			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,769,571	611,234	2,440,165	6,820,970	(27,270)	6,793,700	(562,101)	6,231,599			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.

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					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			81,037	81,037		81,037	274,734	355,771			30
31	Amortization of Pre-Op. & Org.			150,353	150,353		150,353	(150,353)				31
32	Interest			13	13		13	909,954	909,967			32
33	Real Estate Taxes			(134)	(134)	27,270	27,136	276,194	303,330			33
34	Rent-Facility & Grounds			2,082,000	2,082,000		2,082,000	(2,082,000)				34
35	Rent-Equipment & Vehicles			8,615	8,615		8,615	1,278	9,893			35
36	Other (specify):*							51,213	51,213			36
37	TOTAL Ownership			2,321,884	2,321,884	27,270	2,349,154	(718,980)	1,630,174			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			462	462		462		462			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			12,500	12,500		12,500		12,500			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			12,962	12,962		12,962		12,962			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,769,571	611,234	4,775,011	9,155,816		9,155,816	(1,281,081)	7,874,735			45

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

VI. ADJUSTMENT DETAIL

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

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,132)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	4,966	30		9
10	Interest and Other Investment Income	(7,753)	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	(121,900)	21		18
19	Entertainment				19
20	Contributions	(750)	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	(299,676)	21		24
25	Fund Raising, Advertising and Promotional	(5,873)	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	(214,176)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (648,294)		\$	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)	(632,787)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (632,787)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (1,281,081)		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

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Patient Clothing	\$ (350)	10	1
2	Theft Loss	(1,054)	21	2
3	Collection Expense	(2,448)	21	3
4	Alliance for Living - Lobbying	(13,275)	20	4
5	Other Income	(63)	21	5
6	Jury Duty	(25)	10	6
7	Non-Allowable Legal Fees	(5,680)	19	7
8	Capitalized R&M	(9,835)	06	8
9	Annual Report	(250)	20	9
10	Building Company - Filing Fee	(250)	21	10
11	Building Company - Amortization	(8,025)	36	11
12	Amortization for Goodwill	(150,353)	31	12
13	Lobbying Expense	(3,184)	19	13
14	Building Company - Prof fees	(8,700)	19	14
15	Building Company - Mgmt fees	(10,550)	19	15
16	Banking Convenience Fee	(134)	21	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	(214,176)		49

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
50		\$		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary			242									242	1
2	Food Purchase			522									522	2
3	Housekeeping			1,341									1,341	3
4	Laundry													4
5	Heat and Other Utilities	(3,132)		1,871									(1,261)	5
6	Maintenance	(9,835)		3,908	11,710								5,783	6
7	Other (specify):*				1,225								1,225	7
8	TOTAL General Services	(12,967)		7,884	12,935								7,852	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(375)				(915)							(1,290)	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	(375)				(915)							(1,290)	16
	C. General Administration													
17	Administrative			3,912	22,270								26,182	17
18	Directors Fees													18
19	Professional Services	(28,114)	22,951	(348,782)									(353,945)	19
20	Fees, Subscriptions & Promotions	(20,148)		1,270									(18,878)	20
21	Clerical & General Office Expenses	(425,525)	250	7,882	134,950								(282,443)	21
22	Employee Benefits & Payroll Taxes				(6,170)								(6,170)	22
23	Inservice Training & Education													23
24	Travel and Seminar			199									199	24
25	Other Admin. Staff Transportation			1,353									1,353	25
26	Insurance-Prop.Liab.Malpractice		31,506	2,342									33,848	26
27	Other (specify):*				31,191								31,191	27
28	TOTAL General Administration	(473,787)	54,707	(331,824)	182,241								(568,663)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(487,129)	54,707	(323,940)	195,176	(915)							(562,101)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/16 Ending: 12/31/16

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

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	4,966	266,646	3,122									274,734	30
31	Amortization of Pre-Op. & Org.	(150,353)											(150,353)	31
32	Interest	(7,753)	906,372	11,335									909,954	32
33	Real Estate Taxes		270,734	5,460									276,194	33
34	Rent-Facility & Grounds		(2,082,000)										(2,082,000)	34
35	Rent-Equipment & Vehicles			1,278									1,278	35
36	Other (specify):*	(8,025)	59,238										51,213	36
37	TOTAL Ownership	(161,165)	(579,010)	21,195									(718,980)	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)	(648,294)	(524,303)	(302,745)	195,176	(915)							(1,281,081)	45

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.

☒ 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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 2,082,000	Rainbow Beach Real Estate	100.00%	\$	\$(2,082,000)	1
2	V	32	Interest	399	Rainbow Beach Real Estate	100.00%	906,771	906,372	2
3	V	30	Depreciation		Rainbow Beach Real Estate	100.00%	266,646	266,646	3
4	V	19	Audit/Bookkeeping		Rainbow Beach Real Estate	100.00%	8,700	8,700	4
5	V	21	Filing Fee		Rainbow Beach Real Estate	100.00%	250	250	5
6	V	36	Amortization		Rainbow Beach Real Estate	100.00%	8,025	8,025	6
7	V	19	Management Fee		Rainbow Beach Real Estate	100.00%	10,550	10,550	7
8	V	26	Insurance		Rainbow Beach Real Estate	100.00%	31,506	31,506	8
9	V	36	Mortgage Insurance Premiums		Rainbow Beach Real Estate	100.00%	51,213	51,213	9
10	V	33	Real Estate Tax		Rainbow Beach Real Estate	100.00%	270,734	270,734	10
11	V		Real Estate Tax Refund	10,561				\$(10,561)	11
12	V	19	Professional Fees - Tax Appeal				3,701	3,701	12
13	V								13
14	Total			\$ 2,092,960			\$ 1,558,096	\$ * \$(534,864)	14

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Extended Care Consulting, LLC	100.00%	\$ 242	\$ 242	15
16	V	02	Food		Extended Care Consulting, LLC	100.00%	522	522	16
17	V	03	Housekeeping		Extended Care Consulting, LLC	100.00%	1,341	1,341	17
18	V	05	Utilities		Extended Care Consulting, LLC	100.00%	1,871	1,871	18
19	V	06	Maintenance		Extended Care Consulting, LLC	100.00%	3,908	3,908	19
20	V	17	Administrative		Extended Care Consulting, LLC	100.00%	3,912	3,912	20
21	V	19	Professional Fees	356,592	Extended Care Consulting, LLC	100.00%	7,810	(348,782)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC	100.00%	1,270	1,270	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC	100.00%	7,882	7,882	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC	100.00%	199	199	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC	100.00%	1,353	1,353	25
26	V	26	Insurance		Extended Care Consulting, LLC	100.00%	2,342	2,342	26
27	V	30	Depreciation		Extended Care Consulting, LLC	100.00%	3,122	3,122	27
28	V	32	Interest		Extended Care Consulting, LLC	100.00%	11,335	11,335	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC	100.00%	5,460	5,460	29
30	V	35	Rent - Equipment & Auto		Extended Care Consulting, LLC	100.00%	1,278	1,278	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			\$ 53,847	\$ * (302,745)	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance (Pooled)		Extended Care Consulting, LLC	100.00%	11,710	\$ 11,710	15
16	V	06	Maintenance (Direct)	1,560	Extended Care Consulting, LLC	100.00%	1,560		16
17	V	07	Emp. Ben. - Gen. Serv. (Pooled)		Extended Care Consulting, LLC	100.00%	1,097	1,097	17
18	V	07	Emp. Ben. - Gen. Serv. (Direct)		Extended Care Consulting, LLC	100.00%	128	128	18
19	V								19
20	V								20
21	V	17	Administrative (Pooled)		Extended Care Consulting, LLC	100.00%	22,270	22,270	21
22	V	21	Office and Clerical (Pooled)		Extended Care Consulting, LLC	100.00%	134,950	134,950	22
23	V	21	Office and Clerical (Direct)	19,006	Extended Care Consulting, LLC	100.00%	19,006		23
24	V	27	Emp. Ben. - Gen. Admin. (Pooled)		Extended Care Consulting, LLC	100.00%	28,755	28,755	24
25	V	27	Emp. Ben. - Gen. Admin. (Direct)		Extended Care Consulting, LLC	100.00%	2,436	2,436	25
26	V	22	Employee Benefits	6,170	Extended Care Consulting, LLC	100.00%		(6,170)	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			\$ 26,736			\$ 221,912	\$ * 195,176	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	\$ 12,701	MAC Rx, LLC	100.00%	\$ 11,786	\$ (915)	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			\$ 12,701			\$ 11,786	\$ * (915)	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Health Insurance	\$	CCS Employee Benefits Group	100.00%	\$ 158,383	\$ 158,383	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	158,383	CCS Employee Benefits Group	100.00%		(158,383)	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			\$ 158,383			\$ 158,383	\$ *	39

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

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	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.

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		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

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

Facility Name & ID Number

Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	BEECHER	RAINBOW BEACH REAL ESTATE	EVANSTON	BUILDING COMPANY	1
2	GALE ROTHNER	49.00%	BRIAR PLACE LTD.	INDIAN HEAD PARK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT	MAC RX	DES PLAINES	PHARMACY	7
8			MAJOR HOSPITAL DYER	DYER, IN	RELIABLE MEDICAL SUPPLIES	DES PLAINES	MEDICAL SUPPLIES	8
9			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				9
10			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				10
11			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				11
12			MAJOR HOSPITAL SEBOS	HOBART, IN				12
13			MCKINLEY HEALTH CARE CENTER	CANTON, OH				13
14			PARK HOUSE NURSING AND REHABILITATION CENTER, LLC	CHICAGO				14
15			PRAIRIE MANOR NURSING & REHABILITATION CENTER, CHICAGO HEIGHTS					15
16			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				16
17			RAINBOW BEACH QOC, L.L.C.	CHICAGO				17
18			SHEFFIELD MANOR	DYER, IN				18
19			SHERIDAN SHORES CARE & REHABILITATION CENTER, INC.	CHICAGO				19
20			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				20
21			SPRING CREEK NURSING & REHAB CENTER	JOLIET				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			THE PARC AT JOLIET	JOLIET				24
25			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				25
26			TRI-STATE NURSING & REHABILITATION CENTER, INC.	LANSING				26
27			WHEATON CARE CENTER	WHEATON				27
28								28
29								29
30								30

VII. RELATED PARTIES

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

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

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/16 Ending: 12/31/16

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 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Steinberg	Relative	Administrative	0%	See Attached	3.71	6.75%	Alloc Sal/Fee	\$ 13,446	17-7	1
2	Adam Vales	Relative	Clerical	0%	See Attached	0.8	2.00%	Alloc Salary	1,476	22-7	2
3	Kimberly Rudolph	Relative	Clerical	0%	See Attached	0.35	4.66%	Alloc Salary	109	21-7	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	\$ 15,031		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
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0047332

Report Period Beginning:

01/01/16

Ending: 12/31/16

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

Ending: 12/31/16

(847) 905-3030

Facility Name & ID Number Rainbow Beach Care Center# 0047332

Report Period Beginning:

01/01/16Ending: 12/31/16

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

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	1,380,761	34	251,431	251,431	64,305	11,710	1
2	06	Maintenance (Direct)	Direct		20	373,682	373,682		1,560	2
3	07	Emp. Ben. - Gen. Serv. (Pooled)	Patient Days	1,380,761	34	23,565		64,305	1,097	3
4	07	Emp. Ben. - Gen. Serv. (Direct)	Direct		20	46,748			128	4
5										5
6										6
7	17	Administrative (Pooled)	Patient Days	1,380,761	34	478,172	478,172	64,305	22,270	7
8	21	Office and Clerical (Pooled)	Patient Days	1,380,761	34	2,897,656	2,897,656	64,305	134,950	8
9	21	Office and Clerical (Direct)	Direct		24	460,382	460,382		19,006	9
10	27	Emp. Ben. - Gen. Admin. (Pooled)	Patient Days	1,380,761	34	617,434		64,305	28,755	10
11	27	Emp. Ben. - Gen. Admin. (Direct)	Direct		24	73,413			2,436	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					\$ 5,222,483	\$ 4,461,323		\$ 221,912	25

Ending: 12/31/16

(224)220-2730

Ending: 12/31/16

(847)905-4040

Facility Name & ID Number	Rainbow Beach Care Center
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0047332

Report Period Beginning:

01/01/16

Ending: 12/31/16

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

Ending: 12/31/16

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

IL478-2471

Ending: 12/31/16

	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

Ending: 12/31/16

Facility Name & ID Number Rainbow Beach Care Center # 0047332 Report Period Beginning: 01/01/16 Ending: 12/31/16

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	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	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

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

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

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	HUD		X	Mortgage			\$	23,960,247			\$	906,771	1
2													2
3													3
4													4
5					-								5
	Working Capital												
6													6
7													7
8					-								8
9	TOTAL Facility Related						\$	23,960,247			\$	906,771	9
	B. Non-Facility Related*												
10	Interest Income		X									(7,753)	10
11	Other Interest Expense		X									13	11
12	Interest - Bldg Co	X										(399)	12
13	Alloc from Extended Care Cons	X			-							11,335	13
14	TOTAL Non-Facility Related						\$				\$	3,196	14
15	TOTALS (line 9+line14)						\$	23,960,247			\$	909,967	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 51,213 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.)

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

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

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

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

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

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2015 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	274,153	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.)				\$	271,193	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(2,960)	3
4. Real Estate Tax accrual used for 2016 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	279,020	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.)				\$	27,270	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 10,561 For 2013 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.				\$	303,330	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2011	262,176	8		
		2012	252,907	9		
		2013	256,086	10		
		2014	261,098	11		
		2015	265,733	12		
2016 Accrual = \$265,733 x 1.05 = \$279,020						
Allocated from Extended Care Consulting = \$5460						

FOR BHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2015 \$ 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.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rainbow Beach Care Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0047332

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-6300 FAX #: (847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>21-30-112-004-0000</u>	<u>Long Term Care Property</u>	\$ <u>1,845.46</u>	\$ <u>1,845.46</u>
2. <u>21-30-112-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>16,835.65</u>	\$ <u>16,835.65</u>
3. <u>21-30-112-008-0000</u>	<u>Long Term Care Property</u>	\$ <u>18,902.93</u>	\$ <u>18,902.93</u>
4. <u>21-30-112-011-0000</u>	<u>Long Term Care Property</u>	\$ <u>323.09</u>	\$ <u>323.09</u>
5. <u>21-30-112-012-0000</u>	<u>Long Term Care Property</u>	\$ <u>323.09</u>	\$ <u>323.09</u>
6. <u>21-30-112-013-0000</u>	<u>Long Term Care Property</u>	\$ <u>46,389.08</u>	\$ <u>46,389.08</u>
7. <u>21-30-112-014-0000</u>	<u>Long Term Care Property</u>	\$ <u>58,773.23</u>	\$ <u>58,773.23</u>
8. <u>21-30-112-017-0000</u>	<u>Long Term Care Property</u>	\$ <u>974.50</u>	\$ <u>974.50</u>
9. <u>21-30-112-018-0000</u>	<u>Long Term Care Property</u>	\$ <u>980.33</u>	\$ <u>980.33</u>
10. <u>21-30-112-051-0000</u>	<u>Long Term Care Property</u>	\$ <u>111,208.90</u>	\$ <u>111,208.90</u>
TOTALS		\$ <u><u>256,556.26</u></u>	\$ <u><u>256,556.26</u></u>

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2015 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2015 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2015.

Please complete the Real Estate Tax Statement below and include it in the 2016 cost report along with a copy of your 2015 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2015 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Rainbow Beach Care Center

COUNTY

Cook

FACILITY IDPH LICENSE NUMBER

0047332

CONTACT PERSON REGARDING THIS REPORT

Steve Lavenda

TELEPHONE

(847) 236-6300

FAX #:

(847) 236-6301

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2015 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 2015.

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	21-30-112-052-0000	Long Term Care Facility	\$ 9,176.92	\$ 9,176.92
2.	See Attached	Allocated from 2201 W Main St Bld	\$ 117,233.57	\$ 5,459.82
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 126,410.49	\$ 14,636.74

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 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

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.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,645

B. General Construction Type: Exterior BrickFrame BrickNumber of Stories 4

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (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?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (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☒ 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	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility			\$ 485,009	1
2	Allocated from 2201 Main LLC			26,726	2
3	TOTALS			\$ 511,735	3

XI. OWNERSHIP COSTS (continued)

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

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	211			1960	\$ 9,549,265	\$ 250,783	39	\$ 244,853	\$ (5,930)	\$ 2,938,236
5										
6										
7										
8										
	Improvement Type**									
9	Various		2005		39,668		20	1,983	1,983	22,148
10	Various		2006		322,466		20	11,998	11,998	211,060
11	Various		2007		131,026		20	6,039	6,039	87,085
12	Various		2008		248,335		20	11,837	11,837	112,691
13	Various		2009		98,114		20	3,874	3,874	44,177
14	Various		2010		28,177		20	1,409	1,409	9,020
15	Various		2011		61,398		20	2,890	2,890	22,446
16	Various		2012		301,177		20	15,059	15,059	68,937
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
31										
32										
33										
34										
35										
36										

*Total beds on this schedule must agree with page 2.

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

See Page 12A, Line 70 for total

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	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		455,996			22,801	22,801	70,084	67
68		128,626	1,822		1,822		85,840	68
69			96,901			(96,901)		69
70		\$ 11,364,249	\$ 349,506		\$ 324,565	\$ (24,941)	\$ 3,671,724	70

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

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 11,364,249	\$ 349,506		\$ 324,565	\$ (24,941)	\$ 3,671,724	1
2	Replace 16 Thermostats, 16 Adapter Plates & 16 Lock Boxes	2013	6,000		20	1,200	1,200	4,800	2
3	Shower Repair	2013	4,950		20	248	248	990	3
4	Fire Sprinkler System Corrections	2013	11,290		20	565	565	2,258	4
5	Provide & Install Infrared Radiant Heater;Install Sensors/Contro	2013	10,300		20	2,060	2,060	8,240	5
6	Manufacture And Install Clear Vinyl Wall Panels	2013	3,994		20	200	200	782	6
7	Emergency Plumbing Repair	2013	9,330		20	467	467	1,788	7
8	Remove Old Water Coil And Install New One In Kitchen	2013	6,800		20	340	340	1,275	8
9	Install Horizontal Dry Sidewall Sprinkler Heads On 5 Outside Ove	2013	4,127		20	825	825	3,095	9
10	Furnished & Installed Panic Exit Devices - Exterior & Interior Do	2013	3,005		20	601	601	2,154	10
11	Emergency Lights - Fire Pump Room	2013	6,800		20	340	340	1,190	11
12	Add Outlets - Rms 27-34 & 44-59	2013	10,175		20	509	509	1,696	12
13	York Roof Top Units	2013	14,000		20	700	700	2,275	13
14	Rebuild Air Handler On 5Th Floor	2013	2,584		20	129	129	463	14
15	3 L Shaped Nursing Stations	2014	16,500		20	3,300	3,300	8,525	15
16	Chilled Water Pump Assembly	2014	11,483		20	574	574	1,388	16
17	Installation Of Fire Alarm System	2014	9,086		20	454	454	1,060	17
18	Generator Repair	2014	4,420		20	221	221	479	18
19	Patient Room Double Window	2014	4,850		20	243	243	586	19
20	Repair Bathroom Ceiling	2014	3,450		20	173	173	417	20
21	3 Door Closers & Front Entrance Doors	2014	15,625		20	781	781	1,823	21
22	Hot Water Coil	2014	13,519		20	676	676	1,408	22
23	Replace Domestic Booster Pump	2015	6,137		20	307	307	614	23
24	Replace Motor And Sheave In Boiler	2015	3,228		20	161	161	242	24
25	Install Steel Fire Rated Door, Replace 9 Glass Blocks, Caulk 1St F	2015	12,000		20	600	600	650	25
26	Install 4 Shower Drains & 2 Common Drains	2015	3,500		20	175	175	263	26
27	Install New Relay & Controller For Damper	2015	6,626		20	331	331	359	27
28	Install New Pump & Soft Starter For Elevator	2015	17,290		20	865	865	1,513	28
29	Install Detector Edge In Large Passenger Elevator	2015	2,881		20	144	144	252	29
30	Install New Pana 40 Door Edge In Passenger Elevator	2015	3,048		20	152	152	216	30
31	Replace Victalic Seals In # 2 Passenger Elevator	2015	2,898		20	145	145	205	31
32	Boiler Repair	2016	5,454		20	273	273	273	32
33	Sewer Repair	2016	4,500		20	150	150	123	33
34	TOTAL (lines 1 thru 33)		\$ 11,604,099	\$ 349,506		\$ 342,473	\$ (7,033)	\$ 3,723,124	34

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

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,604,099	\$ 349,506		\$ 342,473	\$ (7,033)	\$ 3,723,124	1
2	Sewer Repair	2016	7,150		20	89	89	113	2
3	Sewer Repair	2016	7,600		20	95	95	2,220	3
4	Concrete Walk Way	2016	5,500		20	23	23	150	4
5	Replaced Defective Safety Edge Passenger Elevator	2016	2,629		20	131	131	317	5
6	Replaced Passenger Elevator Mainline, Replaced Door Board	2016	2,619		20	131	131	89	6
7	Replaced Packing On North Passenger Elevator	2016	4,585		20	229	229	95	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,634,182	\$ 349,506		\$ 343,171	\$ (6,335)	\$ 3,726,108	34

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

XI. OWNERSHIP COSTS (continued)

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 11,634,182	\$ 349,506		\$ 343,171	\$ (6,335)	\$ 3,726,108	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,634,182	\$ 349,506		\$ 343,171	\$ (6,335)	\$ 3,726,108	34

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

XI. OWNERSHIP COSTS (continued)

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 11,634,182	\$ 349,506		\$ 343,171	\$ (6,335)	\$ 3,726,108	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 11,634,182	\$ 349,506		\$ 343,171	\$ (6,335)	\$ 3,726,108	34

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

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/16

Ending:

12/31/16

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	29,657	9
10	2 Electromagnetic Locks	2010	4,175		20	209	209	1,462	10
11	Security Camera	2010	2,790		20	140	140	978	11
12	Masonry Repairs	2010	10,820		20	541	541	3,787	12
13	Repair Glass Block	2010	8,700		20	435	435	3,045	13
14	Egress Locks and Delayed Egress Locks	2010	21,800		20	1,090	1,090	7,630	14
15	200 Amp Electric Sub Panel	2010	3,250		20	163	163	1,139	15
16	Privacy Curtains	2010	10,028		20	501	501	3,509	16
17	New Fence	2015	24,500		20	1,225	1,225	2,450	17
18	Installed Floor Tiles in Four Shower Stalls	2015	18,500		20	925	925	1,850	18
19	IP Office Phone System	2015	24,843		20	1,242	1,242	2,484	19
20	Roof Repairs	2016	190,560		20	9,528	9,528	9,528	20
21	1st Floor Bathroom	2016	9,500		20	475	475	475	21
22	Waterproof Membrane	2016	17,000		20	850	850	850	22
23	Fence Painting	2016	9,800		20	490	490	490	23
24	Hot Water Tank	2016	15,000		20	750	750	750	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 455,996	\$		\$ 22,801	\$ 22,801	\$ 70,084	34

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

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

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 455,996	\$		\$ 22,801	\$ 22,801	\$ 70,084	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 455,996	\$		\$ 22,801	\$ 22,801	\$ 70,084	34

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

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning:

01/01/16

Ending:

12/31/16

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

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Related Party		\$	\$		\$	\$	\$	1
2 Buildings:								2
3 Allocated from 2201 Main LLC	2002	36,829	944	39	944		13,496	3
4 Allocated from Extended Care Consulting, LLC - Dyer Bldg	2007	11,177	248	39	248		2,352	4
5								5
6								6
7								7
8 Leasehold Improvements:								8
9 Allocated from Extended Care Consulting, LLC	2007	214	11	20	11		107	9
10 Allocated from Extended Care Consulting, LLC	2009	128	6	20	6		51	10
11 Allocated from Extended Care Consulting, LLC	2010	1,256	63	20	63		440	11
12 Allocated from Extended Care Consulting, LLC	2011	452	23	20	23		136	12
13 Allocated from Extended Care Consulting, LLC	2012	149	7	20	7		37	13
14 Allocated from Extended Care Consulting, LLC	2014	2,066	103	20	103		310	14
15 Allocated from Extended Care Consulting, LLC	2016	2,477	124	20	124		124	15
16								16
17 Allocated from 2201 Main LLC	2002	30,424		20			30,424	17
18 Allocated from 2201 Main LLC	2003	35,854		20			35,854	18
19 Allocated from 2201 Main LLC	2005	1,781	3	20	3		1,781	19
20 Allocated from 2201 Main LLC	2009	321	16	20	16		129	20
21 Allocated from 2201 Main LLC	2014	2,989	149	20	149		448	21
22 Allocated from 2201 Main LLC	2015	507	25	20	25		51	22
23 Allocated from 2201 Main LLC	2016	2,002	100	20	100		100	23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 128,626	\$ 1,822		\$ 1,822	\$	\$ 85,840	34

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

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		\$ 128,626	\$ 1,822		\$ 1,822	\$	\$ 85,840	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 128,626	\$ 1,822		\$ 1,822	\$	\$ 85,840	34

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

XI. OWNERSHIP COSTS (continued)

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

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,432,634	\$1,062	\$12,362	\$11,300	10	\$1,391,458	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	305,911				10	305,911	73
74								74
75	TOTALS	\$1,738,545	\$1,062	\$12,362	\$11,300		\$1,697,369	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		Allocated from Extended Care Co	2016	\$8,405	\$237	\$237		5	\$125	76
77										77
78										78
79										79
80	TOTALS			\$8,405	\$237	\$237			\$125	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$13,892,868	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$350,805	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$355,771	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$4,966	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$5,423,602	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.

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?

☐ YES

☐ NO
- If NO, see instructions.

		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: *

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

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 9,894 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

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.	/2017	\$
13.	/2018	\$
14.	/2019	\$

* 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.

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

☒ 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.

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

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

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

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

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,690	\$ 238,065	1
2	Cash-Patient Deposits	23,270	23,270	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	931,008	931,008	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	245,794	379,774	6
7	Other Prepaid Expenses	5,618	5,618	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		840,494	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,208,380	\$ 2,418,229	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		485,009	13
14	Buildings, at Historical Cost		9,917,320	14
15	Leasehold Improvements, at Historical Cost	992,829	992,829	15
16	Equipment, at Historical Cost	348,746	1,752,590	16
17	Accumulated Depreciation (book methods)	(1,078,839)	(5,874,574)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		280,888	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(57,732)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	1,574,133	1,574,133	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,836,869	\$ 9,070,463	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,045,249	\$ 11,488,692	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 9,089,436	\$ 7,556,293	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,421	8,421	28
29	Short-Term Notes Payable		495,700	29
30	Accrued Salaries Payable	275,494	275,494	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,174	11,174	31
32	Accrued Real Estate Taxes(Sch.IX-B)		279,020	32
33	Accrued Interest Payable		74,876	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	78,146	78,146	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 9,462,671	\$ 8,779,124	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		23,464,547	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			1,132,236	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 24,596,783	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 9,462,671	\$ 33,375,907	46
47	TOTAL EQUITY(page 18, line 24)	\$ (6,417,422)	\$ (21,887,215)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,045,249	\$ 11,488,692	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (5,588,391)	1
2	Restatements (describe):		2
3	Bad Debt	(239,000)	3
4	Repairs & Maintenance	(3,500)	4
5	Depreciation & Rounding	(886)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (5,831,777)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(660,645)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	75,000	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (585,645)	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)	\$ (6,417,422)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rainbow Beach Care Center

0047332

Report Period Beginning: 01/01/16

Ending: 12/31/16

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

1

	I. Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,480,938	1
2	Discounts and Allowances for all Levels	3,639	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,484,577	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	2,753	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)	\$ 2,753	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	7,753	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 7,753	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	88	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 88	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,495,171	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,674,153	31
32	Health Care	2,866,769	32
33	General Administration	2,280,048	33
	B. Capital Expense		
34	Ownership	2,321,884	34
	C. Ancillary Expense		
35	Special Cost Centers	462	35
36	Provider Participation Fee	12,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,155,816	40
41	Income before Income Taxes (line 30 minus line 40)**	(660,645)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (660,645)	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,484,577	44
45	Private Pay - Net Inpatient Revenue		45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify)		47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 8,484,577	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.

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

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,887	2,049	\$ 86,994	\$ 42.46	1
2	Assistant Director of Nursing	1,721	1,991	75,515	37.93	2
3	Registered Nurses	6,492	7,217	213,139	29.53	3
4	Licensed Practical Nurses	23,458	25,749	670,843	26.05	4
5	CNAs & Orderlies	59,411	65,850	763,114	11.59	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	79	84	1,008	12.00	8
9	Activity Director	4,181	4,598	67,407	14.66	9
10	Activity Assistants	10,583	11,522	142,743	12.39	10
11	Social Service Workers	25,501	27,797	554,877	19.96	11
12	Dietician	1,657	1,829	23,095	12.63	12
13	Food Service Supervisor	1,914	2,214	45,910	20.74	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,615	5,140	58,152	11.31	15
16	Dishwashers	14,805	16,495	182,011	11.03	16
17	Maintenance Workers	14,994	16,486	216,293	13.12	17
18	Housekeepers	19,781	21,718	236,909	10.91	18
19	Laundry	53	58	719	12.40	19
20	Administrator	1,905	2,160	118,008	54.63	20
21	Assistant Administrator	975	1,108	40,046	36.14	21
22	Other Administrative					22
23	Office Manager	2,771	3,072	52,353	17.04	23
24	Clerical	5,120	5,858	73,858	12.61	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)	11,806	12,788	146,577	11.46	33
34	TOTAL (lines 1 - 33)	213,709	235,783	\$ 3,769,571 *	\$ 15.99	34

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

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	417	\$ 22,642	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	13,920	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					47
48	Psychiatrist	Monthly	21,000	10-03	48
49	TOTAL (lines 35 - 48)	417	\$ 64,762		49

C. CONTRACT NURSES

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

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Jacquelline Gully	Administrator	0	\$ 118,008
Gianni Seifer	Assnt Administrator	0	40,046
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 158,054
B. Administrative - Other			
Description			Amount
		\$	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Propay Payroll Solution	Data Processing	\$	28,403
Reimb Achieve	Data Processing		24,382
National Datacare Corp	Data Processing		5,117
Extended Care Consulting	Home Office		356,592
Marcum LLP	Accounting Fees		15,851
S4 Group	Lobbying (adj page 5)		3,184
Legal Fees	See Attachment		42,569
Personnel Planners, Inc	Unemployment Fees		2,230
Kelleher, Helmrich	MSDS Services		751
Benefit Services Group	401K Consulting		547
See Supplemental Schedule			7,107
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)			\$ 486,733
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	113,390
Unemployment Compensation Insurance			93,766
FICA Taxes			287,853
Employee Health Insurance			189,555
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Employee Physicals			108
Pension Expense			29,795
Other Employee Expense			4,295
Holiday Expense			3,165
TOTAL (agree to Schedule V, line 22, col.8)			\$ 721,927
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	5,700
Advertising: Employee Recruitment			15,253
Health Care Worker Background Check (Indicate # of checks performed 64)			5,279
Patient Background Checks	356		3,560
Dues and Subscriptions			17,062
Licences and Fees			3,362
Allocated from Extended Care Consulting			1,270
Less: Public Relations Expense		(	
Non-allowable advertising		(	
Yellow page advertising		(	
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 51,486
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			10,963
Allocated from Extended Care Consulting			199
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	11,162

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number <u>Rainbow Beach Care Center</u>	STATE OF ILLINOIS # <u>0047332</u>	Report Period Beginning: <u>01/01/16</u>	Ending: <u>12/31/16</u>
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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?
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?
What was the average life used for new equipment added during this period? Yes
10 Years

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line N/A

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

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

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

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

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 12,500
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 benefit on Schedule V. \$ _____ Has any meal income been offset against related costs? No Indicate the amount. \$ N/A

(16) Travel and Transportation
 a. Are there costs included for out-of-state travel? No
 If YES, attach a complete explanation.
 b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
 c. What percent of all travel expense relates to transportation of nurses and patients? 100% Ln 1
 d. Have vehicle usage logs been maintained? N/A
 e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
 f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A

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

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

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