

		FOR BHF USE					

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2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

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: <u>0054247</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Rainbow Beach Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/20</u> to <u>12/31/20</u> 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.	
Address: <u>7325 South Exchange</u> <u>Chicago</u> <u>60649</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider Paid Preparer	
Telephone Number: <u>(773)731-7300</u> Fax # <u>(773)731-5781</u>			
HFS ID Number: _____			
Date of Initial License for Current Owners: <u>8/1/2005</u>			
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 _____		(Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____ (Signed) _____ (Date) _____ <i>* Subject to the attached Accountants' Consulting Report</i> (Print Name and Title) _____ (Firm Name & Address) <u>Marcum, LLP</u> <u>9 Parkway North, Suite 200 Deerfield, IL 60015</u> (Telephone) <u>(847) 282-6300</u> Fax # <u>(847) 282-6301</u>	
In the event there are further questions about this report, please contact: Name: <u>Steven N. Lavenda</u> Telephone Number: <u>(847) 282-6300</u> Email Address: _____		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: 01/01/20 Ending: 12/31/20

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 <u>N/A</u>					
	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	<u>203</u>	Intermediate (ICF)	<u>203</u>	<u>74,298</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>203</u>	TOTALS	<u>203</u>	<u>74,298</u>	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	<u>61,562</u>			<u>61,562</u>
11	ICF/DD				11
12	SC				12
13	DD 16 OR LESS				13
14	TOTALS	<u>61,562</u>			<u>61,562</u>

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.86%

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 ☒

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 8/1/2005

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 8/1/2005 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 N/A

IV. ACCOUNTING BASIS
ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐
Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/20 Fiscal Year: 12/31/20
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Rainbow Beach Care Center** # **0054247** Report Period Beginning: **01/01/20** Ending: **12/31/20**
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	397,065	42,881	11,572	451,518		451,518	201	451,719			1
2	Food Purchase		400,236		400,236		400,236	147	400,383			2
3	Housekeeping	363,888	67,177		431,065		431,065	1,759	432,824			3
4	Laundry		13,089	38,136	51,225		51,225		51,225			4
5	Heat and Other Utilities			201,915	201,915		201,915	(4,232)	197,683			5
6	Maintenance	326,882		221,598	548,480		548,480	12,847	561,327			6
7	Other (specify):*							5,300	5,300			7
8	TOTAL General Services	1,087,835	523,383	473,221	2,084,439		2,084,439	16,022	2,100,461			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,337,857	98,876	25,382	2,462,115		2,462,115	(1,418)	2,460,697			10
10a	Therapy											10a
11	Activities	238,615	5,410		244,025		244,025		244,025			11
12	Social Services	608,236	36,706		644,942		644,942		644,942			12
13	CNA Training											13
14	Program Transportation			390	390		390		390			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,184,708	140,992	32,972	3,358,672		3,358,672	(1,418)	3,357,254			16
	C. General Administration											
17	Administrative	92,693			92,693		92,693	25,191	117,884			17
18	Directors Fees											18
19	Professional Services			469,969	469,969	(12,340)	457,629	(359,006)	98,623			19
20	Dues, Fees, Subscriptions & Promotions			146,962	146,962		146,962	(43,828)	103,134			20
21	Clerical & General Office Expenses	187,124	25,684	250,407	463,215		463,215	(32,009)	431,206			21
22	Employee Benefits & Payroll Taxes			720,421	720,421		720,421	(3,956)	716,465			22
23	Inservice Training & Education											23
24	Travel and Seminar			955	955		955	535	1,490			24
25	Other Admin. Staff Transportation			24,160	24,160		24,160	1,009	25,169			25
26	Insurance-Prop.Liab.Malpractice			267,438	267,438		267,438	35,786	303,224			26
27	Other (specify):*							37,074	37,074			27
28	TOTAL General Administration	279,817	25,684	1,880,312	2,185,813	(12,340)	2,173,473	(339,204)	1,834,269			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,552,360	690,059	2,386,505	7,628,924	(12,340)	7,616,584	(324,600)	7,291,985			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			55,114	55,114		55,114	330,649	385,763			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			77	77		77	822,229	822,306			32
33	Real Estate Taxes			35,757	35,757	12,340	48,097	215,168	263,265			33
34	Rent-Facility & Grounds			2,082,000	2,082,000		2,082,000	(2,082,000)				34
35	Rent-Equipment & Vehicles			11,845	11,845		11,845	369	12,214			35
36	Other (specify):*							110,581	110,581			36
37	TOTAL Ownership			2,184,793	2,184,793	12,340	2,197,133	(603,004)	1,594,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			98	98		98		98			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			98	98		98		98			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,552,360	690,059	4,571,396	9,813,815		9,813,815	(927,603)	8,886,212			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	(6,158)	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	34,666	30		9
10	Interest and Other Investment Income	(19,215)	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	(29,850)	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	(219,661)	21		24
25	Fund Raising, Advertising and Promotional	(131)	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	(63,833)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (304,182)		\$	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)	(623,421)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (623,421)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (927,603)		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	Other Income	\$ (26)	21	1
2	Patient Clothing	(132)	10	2
3	Theft Loss	(156)	21	3
4	Building Company - Management Fee	(10,550)	19	4
5	Building Company - Audit Fee	(11,900)	19	5
6	Building Company - Filing Fee	(75)	20	6
7	Building Company - Amortization Expense	(8,025)	36	7
8	Convenience Fee	(154)	33	8
9	Building Company - State Replacement Tax	(1,292)	21	9
10	Capitalized R&M	(14,396)	06	10
11	Alliance For Living - Lobbying	(17,127)	20	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				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	(63,833)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			201									201	1
2	Food Purchase			147									147	2
3	Housekeeping			1,759									1,759	3
4	Laundry													4
5	Heat and Other Utilities	(6,158)		1,926									(4,232)	5
6	Maintenance	(14,396)		27,243									12,847	6
7	Other (specify):*			5,300									5,300	7
8	TOTAL General Services	(20,554)		36,576									16,022	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(132)			(1,286)								(1,418)	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	(132)			(1,286)								(1,418)	16
	C. General Administration													
17	Administrative			25,191									25,191	17
18	Directors Fees													18
19	Professional Services	(22,450)	34,370	(370,926)									(359,006)	19
20	Fees, Subscriptions & Promotions	(47,183)	75	3,280									(43,828)	20
21	Clerical & General Office Expenses	(221,135)	1,292	187,834									(32,009)	21
22	Employee Benefits & Payroll Taxes			(3,956)									(3,956)	22
23	Inservice Training & Education													23
24	Travel and Seminar			535									535	24
25	Other Admin. Staff Transportation			1,009									1,009	25
26	Insurance-Prop.Liab.Malpractice		33,624	2,162									35,786	26
27	Other (specify):*			37,074									37,074	27
28	TOTAL General Administration	(290,768)	69,361	(117,797)									(339,204)	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(311,454)	69,361	(81,221)	(1,286)								(324,600)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
30	Depreciation	34,666	292,591	3,392									330,649	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(19,215)	829,322	12,122									822,229	32
33	Real Estate Taxes	(154)	208,575	6,747									215,168	33
34	Rent-Facility & Grounds		(2,082,000)										(2,082,000)	34
35	Rent-Equipment & Vehicles			369									369	35
36	Other (specify):*	(8,025)	118,606										110,581	36
37	TOTAL Ownership	7,272	(632,906)	22,630									(603,004)	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)	(304,182)	(563,545)	(58,591)	(1,286)								(927,603)	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		\$	(2,082,000)	1
2	V	32	Interest	64	Rainbow Beach Real Estate		829,386	829,322	2
3	V	19	Management Fees		Rainbow Beach Real Estate		10,550	10,550	3
4	V	19	Audit Fee		Rainbow Beach Real Estate		11,900	11,900	4
5	V	20	Filing Fee		Rainbow Beach Real Estate		75	75	5
6	V	19	Legal Fees - RE Tax Refund		Rainbow Beach Real Estate		11,920	11,920	6
7	V	30	Depreciation		Rainbow Beach Real Estate		292,591	292,591	7
8	V	36	Amortization		Rainbow Beach Real Estate		8,025	8,025	8
9	V	33	Real Estate Taxes		Rainbow Beach Real Estate		208,575	208,575	9
10	V	21	State Replacement Tax		Rainbow Beach Real Estate		1,292	1,292	10
11	V	26	Insurance		Rainbow Beach Real Estate		33,624	33,624	11
12	V	36	Mortgage Insurance		Rainbow Beach Real Estate		110,581	110,581	12
13	V								13
14	Total			\$ 2,082,064			\$ 1,518,519	\$ * (563,545)	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:

01/01/20

Ending:

12/31/20

VII. RELATED PARTIES

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

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ERIC ROTHNER	51.00%	BEECHER MANOR NURSING AND REHABILITATION CENTER, LLC	BEECHER	RAINBOW BEACH REAL ESTATE		BUILDING COMPANY	1
2	GALE ROTHNER	49.00%	BURBANK REHABILITATION CENTER	BURBANK	EXTENDED CARE CONSULTING	EVANSTON	MGMT/BOOKKEEPING	2
3			CHATEAU NURSING AND REHABILITATION CENTER, L.L.C.	WILLOWBROOK	EXTENDED CARE CLINICAL	EVANSTON	CLINICAL	3
4			COUNTRYSIDE NURSING AND REHABILITATION CENTER, LLC	DOLTON	CARE CENTERS BUILDING	EVANSTON	BUILDING COMPANY	4
5			GRASMERE PLACE, LLC	CHICAGO	VENT LEASE LLC	EVANSTON	NURSING EQUIPMENT	5
6			ESTATES OF HIDDEN LAKE	ST. LOUIS, MO	C.C.S. VEBA	EVANSTON	HEALTH INSURANCE	6
7			LAKEWOOD NURSING & REHABILITATION CENTER, L.L.C.	PLAINFIELD	MAC RX	DES PLAINES	PHARMACY	7
8			LEMONT NURSING AND REHABILITATION CENTER, L.L.C.	LEMONT				8
9			MAJOR HOSPITAL DYER	DYER, IN				9
10			MAJOR HOSPITAL LAKE COUNTY	EAST CHICAGO, IN				10
11			MAJOR HOSPITAL LINCOLNSHIRE	MERRIVILLE, IN				11
12			MAJOR HOSPITAL MUNSTER	MUNSTER, IN				12
13			MAJOR HOSPITAL SEBOS	HOBART, IN				13
14			MAJOR HOSPITAL SPRING MILL HEALTH CAMPUS	MERRIVILLE, IN				14
15			MCKINLEY HEALTH CARE CENTER	CANTON, OH				15
16			PRAIRIE MANOR NURSING & REHABILITATION CENTER, L.L.C.	CHICAGO HEIGHTS				16
17			PRAIRIE VILLAGE HEALTHCARE CENTER, INC.	JACKSONVILLE				17
18			RUSHVILLE NURSING & REHABILITATION CENTER, LLC	RUSHVILLE				18
19			SHEFFIELD MANOR	DYER, IN				19
20			SOUTH HOLLAND MANOR HEALTH & REHAB CENTER	SOUTH HOLLAND				20
21			SOUTH SUBURBAN REHABILITATION CENTER, LLC	HOMEWOOD				21
22			ST. JAMES WELLNESS REHAB VILLAS	CRETE				22
23			THE ESTATES OF HYDE PARK	CHICAGO				23
24			TIMBER POINT HEALTHCARE CENTER, INC.	CAMP POINT				24
25			WESMONT MANOR HEALTH & REHAB CENTER	WESTMONT				25
26								26
27								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

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		\$ 201	\$ 201	15
16	V	02	Food		Extended Care Consulting, LLC		147	147	16
17	V	03	Housekeeping		Extended Care Consulting, LLC		1,759	1,759	17
18	V	05	Utilities		Extended Care Consulting, LLC		1,926	1,926	18
19	V	06	Maintenance		Extended Care Consulting, LLC		3,837	3,837	19
20	V	17	Administrative		Extended Care Consulting, LLC				20
21	V	19	Professional Fees	378,768	Extended Care Consulting, LLC		7,842	(370,926)	21
22	V	20	Dues and Subscriptions		Extended Care Consulting, LLC		3,280	3,280	22
23	V	21	Office and Clerical		Extended Care Consulting, LLC		17,271	17,271	23
24	V	24	Seminar and Travel		Extended Care Consulting, LLC		535	535	24
25	V	25	Other Staff Admin. Trans.		Extended Care Consulting, LLC		1,009	1,009	25
26	V	26	Insurance		Extended Care Consulting, LLC		2,162	2,162	26
27	V	30	Depreciation		Extended Care Consulting, LLC		3,392	3,392	27
28	V	32	Interest		Extended Care Consulting, LLC		12,122	12,122	28
29	V	33	Real Estate Taxes		Extended Care Consulting, LLC		6,747	6,747	29
30	V	35	Rent - Equipment		Extended Care Consulting, LLC		369	369	30
31	V	06	Maintenance Salaries	5,653	Extended Care Consulting, LLC		29,059	23,406	31
32	V	07	Emp. Ben. - Gen. Serv.		Extended Care Consulting, LLC		5,300	5,300	32
33	V	17	Administrative Salaries		Extended Care Consulting, LLC		25,191	25,191	33
34	V	21	Office and Clerical Salaries	7,534	Extended Care Consulting, LLC		178,097	170,563	34
35	V	27	Emp. Ben. - Gen. Admin.		Extended Care Consulting, LLC		37,074	37,074	35
36	V	22	Employee Benefits	3,956	Extended Care Consulting, LLC			(3,956)	36
37	V								37
38	V								38
39	Total			\$ 395,911			\$ 337,320	\$ * (58,591)	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	\$ 17,882	MAC Rx, LLC		\$ 16,210	\$ (1,286)	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			\$ 17,882			\$ 16,210	\$ * (1,286)	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		\$ 135,796	\$ 135,796	15
16	V								16
17	V								17
18	V								18
19	V	22	Employee Health Insurance	135,796	CCS Employee Benefits Group			(135,796)	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			\$ 135,796			\$ 135,796	\$ *	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.

YESNO

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 # 0054247 Report Period Beginning: 01/01/20 Ending: 12/31/20

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	Adam Vales	Relative	Clerical	0	See Attached	0.68	1.69%	Alloc Salary	\$ 1,207	22-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,207		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: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Rainbow Beach Care Center# 0054247

Report Period Beginning:

01/01/20Ending: 12/31/20

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	2	3	4	5	6	7	8	9	
Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
Line	Item	(i.e.,Days, Direct Cost, Square Feet)	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
Reference				Allocated Among	Allocated	in Column 6			
1	01	Dietary	Patient Days	38	\$ 3,992	\$	61,562	\$ 201	1
2	02	Food	Patient Days	38	2,910		61,562	147	2
3	03	Housekeeping	Patient Days	38	34,856		61,562	1,759	3
4	05	Utilities	Patient Days	38	38,173		61,562	1,926	4
5	06	Maintenance	Patient Days	38	76,040		61,562	3,837	5
6	17	Administrative	Patient Days	38			61,562		6
7	19	Professional Fees	Patient Days	38	155,408		61,562	7,842	7
8	20	Dues and Subscriptions	Patient Days	38	64,998		61,562	3,280	8
9	21	Office and Clerical	Patient Days	38	342,251		61,562	17,271	9
10	24	Seminar and Travel	Patient Days	38	10,602		61,562	535	10
11	25	Other Staff Admin. Trans.	Patient Days	38	19,988		61,562	1,009	11
12	26	Insurance	Patient Days	38	42,836		61,562	2,162	12
13	30	Depreciation	Patient Days	38	67,209		61,562	3,392	13
14	32	Interest	Patient Days	38	240,208		61,562	12,122	14
15	33	Real Estate Taxes	Patient Days	38	133,701		61,562	6,747	15
16	35	Rent - Equipment	Patient Days	38	7,304		61,562	369	16
17	06	Maintenance Salaries	Patient Days	38	575,856	575,856	61,562	29,059	17
18	07	Emp. Ben. - Gen. Serv.	Patient Days	38	105,021		61,562	5,300	18
19	17	Administrative Salaries	Patient Days	38	499,202	499,202	61,562	25,191	19
20	21	Office and Clerical Salaries	Patient Days	38	3,529,267	3,529,267	61,562	178,097	20
21	27	Emp. Ben. - Gen. Admin.	Patient Days	38	734,685		61,562	37,074	21
22									22
23									23
24									24
25	TOTALS				\$ 6,684,506	\$ 4,604,325		\$ 337,320	25

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/20 Ending: 12/31/20

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 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	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	10	Nursing And Medical Records	Direct Allocation			\$	\$		\$ 16,210	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					\$	\$		\$ 16,210	25

Ending: 12/31/20

(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			\$	\$		\$ 135,796	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					\$	\$		\$ 135,796	25

Ending: 12/31/20

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

IL478-2471

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Ending: 12/31/20

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/20 Ending: 12/31/20

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

Facility Name & ID Number Rainbow Beach Care Center # 0054247 Report Period Beginning: 01/01/20 Ending: 12/31/20

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			\$	21,861,063			\$	829,386	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$	21,861,063			\$	829,386	9
	B. Non-Facility Related*												
10	Interest Income		X									(19,215)	10
11	Other Interest Expense		X									77	11
12	Interest Income - Bldg Co		X									(64)	12
13	Alloc from Extended Care Consulting											12,122	13
14	TOTAL Non-Facility Related						\$				\$	(7,080)	14
15	TOTALS (line 9+line14)						\$	21,861,063			\$	822,306	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 110,581 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 (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		\$	319,513	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.)				\$	281,718	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(37,795)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	288,720	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.)				\$	12,340	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 \$ 35,757 For 2017 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.				\$	263,265	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:		2015	265,733	8	FOR BHF USE ONLY	
		2016	287,847	9		
		2017	307,728	10	13	FROM R. E. TAX STATEMENT FOR 2019 \$ 13
		2018	304,298	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
2020 Accrual = \$274,971 x 1.05 = \$288,720		2019	274,971	12	15	LESS REFUND FROM LINE 6 \$ 15
Allocated from Extended Care Consulting \$6747					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.

2019 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 Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2019 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 2019.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 21-30-112-004-0000	Long Term Care Property	\$ 2,023.80	\$ 2,023.80
2. 21-30-112-007-0000	Long Term Care Property	\$ 17,186.07	\$ 17,186.07
3. 21-30-112-008-0000	Long Term Care Property	\$ 19,291.38	\$ 19,291.38
4. 21-30-112-011-0000	Long Term Care Property	\$ 413.06	\$ 413.06
5. 21-30-112-012-0000	Long Term Care Property	\$ 413.06	\$ 413.06
6. 21-30-112-013-0000	Long Term Care Property	\$ 47,365.93	\$ 47,365.93
7. 21-30-112-014-0000	Long Term Care Property	\$ 59,975.93	\$ 59,975.93
8. 21-30-112-017-0000	Long Term Care Property	\$ 1,243.85	\$ 1,243.85
9. 21-30-112-018-0000	Long Term Care Property	\$ 1,251.71	\$ 1,251.71
10. 21-30-112-051-0000	Long Term Care Property	\$ 114,524.48	\$ 114,524.48
TOTALS		\$ 263,689.27	\$ 263,689.27

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 copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

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

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 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 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 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.

2019 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 Steven Lavenda

TELEPHONE () FAX #: ()

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	\$ 11,281.82	\$ 11,281.82
2. See Attached	Alloc from Extended Care Consulting	\$ 197,162.69	\$ 6,746.94
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 208,444.51	\$ 18,028.76

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

Brick

Frame

Brick

Number 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 Care Center Building			28,061	2
3	TOTALS			\$ 513,070	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	203			1960	\$ 9,549,265	\$ 292,591	39	\$ 244,853	\$ (47,738)	\$ 3,917,648	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Various			2005	39,668		20	1,983	1,983	30,081	9	
10	Various			2006	322,466		20	11,999	11,999	259,054	10	
11	Various			2007	131,026		20	3,906	3,906	106,279	11	
12	Various			2008	248,335		20	11,838	11,838	160,044	12	
13	Various			2009	98,114		20	4,618	4,618	59,913	13	
14	Various			2010	28,178		20	1,408	1,408	14,654	14	
15	Various			2011	61,398		20	2,746	2,746	33,861	15	
16	Various			2012	301,177		20	15,061	15,061	129,174	16	
17	Various			2013	93,355		20	3,498	3,498	50,137	17	
18	Various			2014	78,933		20	3,122	3,122	36,148	18	
19	Various			2015	57,608		20	2,880	2,880	15,834	19	
20	Various			2016	40,037		20	2,002	2,002	8,947	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

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)		724,056			36,452	36,452	207,650	67
68	Related Party Allocations (Pages 12H & 12I)		141,869	2,241		2,241		99,240	68
69	Financial Statement Depreciation			55,114			(55,114)		69
70	TOTAL (lines 4 thru 69)		\$ 11,915,485	\$ 349,946		\$ 348,607	\$ (1,339)	\$ 5,128,664	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:

01/01/20

Ending:

12/31/20

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		\$ 11,915,485	\$ 349,946		\$ 348,607	\$ (1,339)	\$ 5,128,664	1
2	Fire Alarm System - New Annunciator For Floors 1-5	2017	6,089		20	304	304	1,217	2
3	Southwest Cafeteria Fire Exit Door	2017	10,350		20	518	518	1,984	3
4	2Nd Floor Bathroom Remodel-New Showers, Floor & Wall Tile	2017	9,060		20	453	453	1,699	4
5	Masonry Tuck Pointing - Back Of Building	2017	40,000		20	2,000	2,000	7,500	5
6	2Nd Floor Bathroom - New Showers, Drains, Walls	2017	7,700		20	385	385	1,412	6
7	Duct Work Replacement & New Air Conditioners	2017	6,816		20	341	341	3,749	7
8	Magnetic Locks On 1St Floor	2017	3,852		20	193	193	658	8
9	Hvac - Roof Top Exhaust Fan Replacement	2017	3,000		20	150	150	500	9
10	5Th Floor Roof Coating	2017	4,900		20	245	245	796	10
11	1St Floor Roof Coating	2017	3,500		20	175	175	569	11
12	Repack Cylinder Heads On Elevator	2017	3,450		20	173	173	676	12
13	Replaced Pump Motor On Elevator	2017	7,495		20	375	375	1,406	13
14	Install New Door Board In Large Elevator	2017	3,270		20	164	164	586	14
15	Install New Selector Board In Elevator #1	2017	7,788		20	389	389	1,265	15
16	Install New Car Board In Big Passenger Elevator	2017	5,550		20	278	278	902	16
17	Install New Clc Board In Large Passenger Elevator	2017	2,855		20	143	143	440	17
18	Elevator Maintenance On Both Elevators	2017	4,267		20	213	213	657	18
19	Install New Clc Board In Large Passenger Elevator	2017	3,307		20	165	165	509	19
20	Repair Wiring On P24C Circuit In Large Passenger Elevator	2017	2,501		20	125	125	386	20
21	Install New Door Board In Elevator #1	2017	4,941		20	247	247	885	21
22	Window Screen Replacement & Laundry Water Valves	2018	7,650		20	383	383	1,052	22
23	3Rd Floor Hvac Duct Work Replacement	2018	6,915		20	346	346	951	23
24	3Rd Floor Hvac Duct Work Replacement, Door Parts For Lunch I	2018	5,050		20	253	253	695	24
25	3Rd Floor Hvac Duct Work Replacement	2018	7,950		20	398	398	1,094	25
26	Kitchen Plumbing/3Rd Flr Hvac Ductwork/Lighting	2018	7,850		20	393	393	1,080	26
27	Replace Elevator Sump Pump/Ground Fl Hvac Duct Repair	2018	7,850		20	393	393	1,080	27
28	Clean Windows, Tuckpoint By Patio, Bathroom Demo	2018	7,410		20	371	371	1,019	28
29	Front Hall Mens Bathrm-Walls/Ceiling Painting, Fixtures, Plumbi	2018	8,690		20	435	435	1,159	29
30	Womens Bathrm-Wall Painting, Ceiling Tiles, Electrical Repair	2018	6,250		20	313	313	834	30
31	New Roof Top Ac Unit	2018	12,500		20	625	625	1,667	31
32	Trane Chiller - New Keypad	2018	4,226		20	211	211	563	32
33	Installed New Electrical Junction Box	2018	6,285		20	314	314	812	33
34	TOTAL (lines 1 thru 33)		\$ 12,144,802	\$ 349,946		\$ 360,078	\$ 10,132	\$ 5,168,466	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:

01/01/20

Ending:

12/31/20

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 12B, Carried Forward		\$ 12,144,802	\$ 349,946		\$ 360,078	\$ 10,132	\$ 5,168,466	1
2	Resident Room Windows & Dry Wall Replacement	2018	6,480		20	324	324	783	2
3	Boiler Room-Insulate Water Pipes/Repair Window Frames	2018	6,165		20	308	308	719	3
4	Resident Rms-Install 5 New Light Fixtures/Repair Damaged Walls	2018	6,350		20	318	318	741	4
5	Rms 49-51,53,56,59-Dry Wall Repairs/Caulked Doors & Windows	2018	6,220		20	311	311	726	5
6	Resident Room Window Replacement / Activity Room Door Repair	2018	4,550		20	228	228	531	6
7	Resident Room Window Replacement	2018	3,527		20	176	176	411	7
8	Resident Room Window Replacement	2018	6,955		20	348	348	812	8
9	Install New Electrical Panel	2018	11,000		20	550	550	1,375	9
10	Exit Door Hardware & Window Screen Replacement	2018	5,200		20	260	260	758	10
11	New Bathroom Sink, Window Screen Replacement, New Lighting	2018	11,070		20	554	554	1,569	11
12	Service A/C Units, Window Screen Replacement, Repoured Concrete	2018	7,060		20	353	353	912	12
13	Rod Out Toilets, Exit Sign Installation, Window Screen Replacement	2018	6,935		20	347	347	896	13
14	Electrical Work On Back Of Facility, New Lighting Fixtures, Insulation	2018	7,780		20	389	389	1,005	14
15	Resident Rms-Plumbing Repairs, Wall Painting, Electrical Repair	2018	7,930		20	397	397	1,025	15
16	Front Hallway Washroom - Drywall, Paint, New Fixtures	2018	6,740		20	337	337	899	16
17	Resident Room Window & Screen Replacement	2018	4,540		20	227	227	492	17
18	Resident Room Window Replacement & Plumbing Repairs	2018	5,949		20	297	297	644	18
19	Replace Packing On The Elevator & Add Hydro Oil	2018	3,239		20	162	162	432	19
20	Exterior Heater Exhaust Vent Replacement/Backflow Preventer	2018	4,920		20	246	246	492	20
21	Plumbing System Repair	2018	9,800		20	490	490	980	21
22	Replace Various Resident Room Windows	2018	18,878		20	944	944	1,888	22
23	Multiple Plumbing Replacement Jobs.	2019	12,833		20	642	642	1,177	23
24	Replacement Of Hot Water Coil In Make Up Air Unit On Roof.	2019	6,595		20	330	330	412	24
25	Resident Room Window Replacement	2019	6,490		20	325	325	406	25
26	Resident Room Exterior Window Replacement	2019	4,735		20	237	237	296	26
27	Fourth Floor Shower Remodel	2019	15,500		20	775	775	904	27
28	Resident Rm Window Replacement & Repair/Brick Repair/Plumbing	2019	20,815		20	1,041	1,041	2,082	28
29	Window Part Replacements & Repair On 1St Floor	2019	7,890		20	395	395	724	29
30	Repair Pipe In Main Sewer	2019	15,000		20	750	750	1,250	30
31	Repaired Six Fan Coils On 2Nd Floor	2019	2,738		20	137	137	274	31
32	Installed New Fire/Smoke Damper Motor	2019	5,787		20	289	289	578	32
33	Elevator-Remove Cylinder From Car Sling,Refasten Cylinder Joint	2019	3,950		20	198	198	396	33
34	TOTAL (lines 1 thru 33)		\$ 12,398,423	\$ 349,946		\$ 372,763	\$ 22,817	\$ 5,195,055	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:

01/01/20

Ending:

12/31/20

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 12C, Carried Forward		\$ 12,398,423	\$ 349,946		\$ 372,763	\$ 22,817	\$ 5,195,055	1
2	Repaired Clutch Arm - Passenger Elevator	2019	3,699		20	185	185	370	2
3	Replaced Boiler	2020	12,300		20	615	615	615	3
4	Elevator-Replace Lc Board, Repair 4Th Floor Button	2020	4,182		20	209	209	209	4
5	Elevator-Installation Of New Bloard On Small Passenger Elevator	2020	3,745		20	187	187	187	5
6	Installed Covid-19 Safety Guards Throughout Facility	2020	5,020		20	251	251	251	6
7	Install New 6 Ton Roof Top Unit	2020	17,757		20	888	888	888	7
8	Safety Screen Installation	2020	10,866		20	543	543	543	8
9	Stain Existing Fence & Repair Damaged Pickets	2020	14,800		20	740	740	740	9
10	1St And 5Th Floor Roof Coating	2020	38,000		20	1,900	1,900	1,900	10
11	Installation Of New Alarms By Stairs Of Each Floor With Annunc	2020	16,068		20	803	803	803	11
12	Glass Block Panel Repair - North & South Side Of Building	2020	40,521		20	2,026	2,026	2,026	12
13	New Boiler Pump Assembly	2020	4,850		20	243	243	243	13
14	Dining Rm Air Handler Motor Repair	2020	2,748		20	137	137	137	14
15	Repair Leak In Elevator	2020	3,495		20	175	175	175	15
16	Repair Fire Alarm Panel	2020	4,877		20	244	244	244	16
17	Install Main Motherboard For Elevator Panel	2020	3,275		20	164	164	164	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)		\$ 12,584,626	\$ 349,946		\$ 382,073	\$ 32,127	\$ 5,204,550	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 12D, Carried Forward		\$12,584,626	\$349,946		\$382,073	\$32,127	\$5,204,550	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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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)		\$12,584,626	\$349,946		\$382,073	\$32,127	\$5,204,550	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:

01/01/20

Ending:

12/31/20

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	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	46,605	9
10	2 Electromagnetic Locks	2010	4,175		20	209	209	2,298	10
11	Security Camera	2010	2,790		20	140	140	1,538	11
12	Masonry Repairs	2010	10,820		20	541	541	5,951	12
13	Repair Glass Block	2010	8,700		20	435	435	4,785	13
14	Egress Locks and Delayed Egress Locks	2010	21,800		20	1,090	1,090	11,990	14
15	200 Amp Electric Sub Panel	2010	3,250		20	163	163	1,791	15
16	Privacy Curtains	2010	10,028		20	501	501	5,513	16
17	New Fence	2015	24,500		20	1,225	1,225	7,350	17
18	Installed Floor Tiles in Four Shower Stalls	2015	18,500		20	925	925	5,550	18
19	IP Office Phone System	2015	24,843		20	1,242	1,242	7,452	19
20	Roof Repairs	2016	185,610		20	9,528	9,528	47,640	20
21	1st Flr Bathroom-new concrete floors, shower wall/floor tile, caulk	2016	9,500		20	475	475	2,375	21
22	Waterproof Membrane	2016	17,000		20	850	850	4,250	22
23	Fence Painting	2016	9,800		20	490	490	2,450	23
24	Hot Water Tank	2016	15,000		20	750	750	3,750	24
25	1st Flr Bathroom-new concrete floors/plumbing,wall/floor tile	2017	14,990		20	750	750	2,750	25
26	1st Floor Bathroom - new floor tile, repair & paint walls	2017	3,850		20	193	193	707	26
27	Masonry Tuckpointing - Back of Building	2017	48,000		20	2,400	2,400	8,600	27
28	Electrical Work-offices, kitchen, remove exhaust fan	2017	4,190		20	210	210	752	28
29	Duct Work Replacement & New Air Conditioners	2017	30,450		20	1,523	1,523	6,092	29
30	Masonry Tuckpointing	2017	48,000		20	2,400	2,400	8,200	30
31	New exterior door and masonry	2017	10,000		20	500	500	1,667	31
32	1st Floor Roof Coating	2017	13,050		20	653	653	2,122	32
33	Masonry Tuckpointing - Back of Building	2017	48,000		20	2,400	2,400	7,600	33
34	TOTAL (lines 1 thru 33)		\$ 671,576	\$		\$ 33,828	\$ 33,828	\$ 199,776	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:

01/01/20

Ending:

12/31/20

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		\$ 671,576	\$		\$ 33,828	\$ 33,828	\$ 199,776	1
2	HVAC Duct Work	2018	4,200		20	210	210	630	2
3	HVAC Duct Work & Water Fountain Replacement	2018	7,415		20	371	371	1,113	3
4	HVAC Duct Work & Water Fountain Replacement	2018	5,500		20	275	275	825	4
5	Resident Rm-Toilet Repair/Light Fixtures/Window Screen Replac	2018	8,950		20	448	448	1,344	5
6	Window Screen Replacement - Ground Floor	2018	8,500		20	425	425	1,275	6
7	Window Screen Replacement - Ground Floor	2018	6,755		20	338	338	1,014	7
8	Window Screen Replacement & Replace Back Door Hardware	2018	4,745		20	237	237	711	8
9	Window Screen Replacement - Ground Floor	2018	6,415		20	321	321	963	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)		\$ 724,056	\$		\$ 36,452	\$ 36,452	\$ 207,650	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:

01/01/20

Ending:

12/31/20

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	38,669	991	35	991		18,136	3
4	Allocated from Extended Care Consulting - Dyer Building	2007	12,111	268	35	268		3,622	4
5									5
6									6
7	Leasehold Improvements:								7
8	Allocated from Extended Care Consulting-Care Center Bldg	2002	31,943		20			31,943	8
9	Allocated from Extended Care Consulting-Care Center Bldg	2003	37,644		20			37,644	9
10	Allocated from Extended Care Consulting-Care Center Bldg	2005	1,870		20			1,870	10
11	Allocated from Extended Care Consulting-Care Center Bldg	2009	337	17	20	17		202	11
12	Allocated from Extended Care Consulting-Care Center Bldg	2014	3,239	162	20	162		1,134	12
13	Allocated from Extended Care Consulting-Care Center Bldg	2015	532	27	20	27		344	13
14	Allocated from Extended Care Consulting-Care Center Bldg	2016	2,102	105	20	105		526	14
15	Allocated from Extended Care Consulting-Care Center Bldg	2017	3,646	182	20	182		729	15
16	Allocated from Extended Care Consulting-Care Center Bldg	2018	1,671	84	20	84		251	16
17	Allocated from Extended Care Consulting-Care Center Bldg	2019	629	31	20	31		63	17
18	Allocated from Extended Care Consulting-Care Center Bldg	2020	168	8	20	8		8	18
19									19
20	Allocated from Extended Care Consulting	2007	232	12	20	12		162	20
21	Allocated from Extended Care Consulting	2009	139	7	20	7		84	21
22	Allocated from Extended Care Consulting	2010	1,361	68	20	68		749	22
23	Allocated from Extended Care Consulting	2011	490	24	20	24		245	23
24	Allocated from Extended Care Consulting	2012	161	8	20	8		73	24
25	Allocated from Extended Care Consulting	2014	2,238	112	20	112		783	25
26	Allocated from Extended Care Consulting	2016	2,684	134	20	134		671	26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 141,869	\$ 2,241		\$ 2,241	\$	\$ 99,240	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		\$141,869	\$2,241		\$2,241	\$	\$99,240	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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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)		\$141,869	\$2,241		\$2,241	\$	\$99,240	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	\$30,514	\$1,150	\$3,051	\$1,901	10	\$19,877	71
72	Current Year Purchases	6,380		638	638	10	638	72
73	Fully Depreciated Assets	1,729,714				10	1,729,714	73
74								74
75	TOTALS	\$1,766,608	\$1,150	\$3,689	\$2,539		\$1,750,229	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		Alloc. Extended Care Consulting	2014	\$1,285	\$	\$	\$	5	\$1,285	76
77										77
78										78
79										79
80	TOTALS			\$1,285	\$	\$	\$		\$1,285	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)	\$14,865,588	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$351,096	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$385,762	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$34,666	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$6,956,064	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?
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:
- *

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: \$12,214
- Description: See Attached

(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.	/2021	\$
13.	/2022	\$
14.	/2023	\$

* 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 prescripts							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.

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	\$ 2,217,105	\$ 2,368,326	1
2	Cash-Patient Deposits	56,204	56,204	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,016,412	1,016,412	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	97,599	225,979	6
7	Other Prepaid Expenses	4,122	4,122	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached	1,728	736,745	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,393,170	\$ 4,407,788	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		9,671,360	14
15	Leasehold Improvements, at Historical Cost	1,509,498	2,028,468	15
16	Equipment, at Historical Cost	422,424	1,826,268	16
17	Accumulated Depreciation (book methods)	(1,338,394)	(7,317,487)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached	1,122,192	1,313,248	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,715,720	\$ 8,006,866	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 5,108,890	\$ 12,414,654	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 5,056,895	\$ 5,056,896	26
27	Officer's Accounts Payable	400,000	400,000	27
28	Accounts Payable-Patient Deposits	45,052	45,052	28
29	Short-Term Notes Payable		575,786	29
30	Accrued Salaries Payable	241,594	241,594	30
	Accrued Taxes Payable (excluding real estate taxes)	3,997	3,997	31
32	Accrued Real Estate Taxes(Sch.IX-B)		288,720	32
33	Accrued Interest Payable		68,316	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached	968,300	968,300	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 6,715,838	\$ 7,648,661	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		21,285,277	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached	5,773,299	4,867,438	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 5,773,299	\$ 26,152,715	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 12,489,137	\$ 33,801,376	46
47	TOTAL EQUITY(page 18, line 24)	\$ (7,380,247)	\$ (21,386,722)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 5,108,890	\$ 12,414,654	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (8,177,471)	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (8,177,470)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	797,223	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)	\$ 797,223	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)	\$ (7,380,247)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Rainbow Beach Care Center

0054247

Report Period Beginning: 01/01/20

Ending: 12/31/20

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	\$ 8,828,488	1
2	Discounts and Allowances for all Levels	(3,203)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,825,285	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		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	30,401	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 30,401	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,215	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 19,215	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached	1,736,137	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,736,137	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,611,038	30

2

	II. Expenses	Amount	
	A. Operating Expenses		
31	General Services	2,084,439	31
32	Health Care	3,358,672	32
33	General Administration	2,185,813	33
	B. Capital Expense		
34	Ownership	2,184,793	34
	C. Ancillary Expense		
35	Special Cost Centers	98	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)*	\$ 9,813,815	40
41	Income before Income Taxes (line 30 minus line 40)**	797,223	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 797,223	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	\$ 8,825,285	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)	\$ 8,825,285	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	2,070	2,240	\$ 108,158	\$ 48.28	1
2	Assistant Director of Nursing	1,923	2,097	80,067	38.18	2
3	Registered Nurses	7,876	8,282	288,437	34.83	3
4	Licensed Practical Nurses	19,422	21,485	657,542	30.60	4
5	CNAs & Orderlies	55,002	61,339	1,067,468	17.40	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,490	3,905	65,455	16.76	9
10	Activity Assistants	10,437	11,239	173,160	15.41	10
11	Social Service Workers	25,366	27,456	586,428	21.36	11
12	Dietician					12
13	Food Service Supervisor	3,867	4,073	70,305	17.26	13
14	Head Cook	5,988	6,335	102,592	16.20	14
15	Cook Helpers/Assistants	12,856	14,193	224,168	15.79	15
16	Dishwashers					16
17	Maintenance Workers	17,322	18,680	326,882	17.50	17
18	Housekeepers	21,419	23,309	363,888	15.61	18
19	Laundry					19
20	Administrator	2,101	2,161	92,693	42.89	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	3,617	3,921	77,392	19.74	23
24	Clerical	5,311	6,046	109,732	18.15	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	9,074	9,766	157,993	16.18	33
34	TOTAL (lines 1 - 33)	207,141	226,528	\$ 4,552,360 *	\$ 20.10	34

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	232	\$ 11,572	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	13,382	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)	232	\$ 44,154		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

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

STATE OF ILLINOIS

Page 21

Facility Name & ID Number

Rainbow Beach Care Center

0054247

Report Period Beginning:

01/01/20

Ending:

12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sandra Knox	Administrator	0	\$ 92,356
Vickie George	Admin in Training	0	337
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 92,693

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
Marcum LLP	Accounting	\$ 20,800
Extended Care Consulting	Home Office Expense	378,768
Personnel Planners	Unemployment Consultant	570
Pinnacle Quality Insight	Satisfaction Survey	417
Skidelsky and Associates	Real Estate Tax Appeal	400
Red Eyed Moose	Software Support	4,725
Resolute Healthcare	Healthcare Consultant	4,205
Benefits Services	Employee Benefits Consult	327
Navex Global	Risk & Compliance	428
National Datacare Corporation	Data Processing	2,931
See Attached	Legal	7,391
See Supplemental Schedule		49,008
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		\$ 469,969

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	\$ 107,057
Unemployment Compensation Insurance	32,679
FICA Taxes	348,256
Employee Health Insurance	180,281
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	41,221
Other Employee Welfare	4,521
Holiday Expense	2,450
TOTAL (agree to Schedule V, line 22, col.8)	\$ 716,465

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	57,456
Health Care Worker Background Check (Indicate # of checks performed 155)	1,557
Patient Background Checks	
Dues & Subscriptions	31,942
Licenses & Fees	3,200
See Supplemental Schedule	3,280
Less: Public Relations Expense	()
Non-allowable advertising	()
Yellow page advertising	()
TOTAL (agree to Sch. V, line 20, col. 8)	\$ 103,135

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	\$
In-State Travel	
Seminar Expense	955
See Supplemental Schedule	535
Entertainment Expense	()
(agree to Sch. V, line 24, col. 8)	
TOTAL	\$ 1,490

* Attach copy of IMRF notifications

**See instructions.

HFS 3745 (N-4-99)

IL478-2471

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.

Yes
Alliance for Living \$27,372

(3)

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

Yes
Yes

(4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

No
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.

\$ 174 Line 10

(7)

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

Yes

(8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

No
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?
If YES, attach an explanation of the allocation.

No

(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?
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.

No

(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?
If YES, attach a complete explanation.

No

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

No
\$ N/A

c.

What percent of all travel expense relates to transportation of nurses and patients?

100% Ln 14

d.

Have vehicle usage logs been maintained?

N/A

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

No
\$ N/A

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:

No
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.
Attach invoices and a summary of services for all architect and appraisal fees.

Yes